Drop-in clinics for teenagers in Primary Care: a study to determine their acceptability, effectiveness and cost

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MD thesis

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Declaration

I declare that:

1) I have composed this MD thesis

2) I made a substantial contribution to the work of the research team whose members are given in the text. This contribution was as follows

- The original idea was mine
- The pilot project on which the research was based was conceived and conducted by me
- I instigated the funding applications that allowed the project to take place
- I approached the other members of the team and invited them to take part
- I was involved with every stage of design, conduct and evaluation of the project

3) This work has not been submitted for any other degree or professional qualification

Signed

Dr Richard Ayres Aug 2002

THE UNIVERSITY OF EDINBURGH

ABSTRACT OF THESIS

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Title of Thesis Drop-in clinics for teenagers: A Study to determine their acceptibility, effectiveness and cost.....

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Objective 1) To investigate teenagers views on and use of sexual health services, and to explore barriers to accessing contraception. 2)To see whether the introduction of dedicated nurse-run general practice-based teenage drop-in clinics for sexual health would increase the uptake of contraceptive services by young people as compared to traditional GP services

Design Qualitative data was collected via Focus Group Discussions and questionnaires. Attendance data for teenagers was obtained from the Health Authority and Family Planning service. Effectiveness and cost were investigated by means of a cluster randomised controlled trial in general practice.

Setting Rural and urban communities in the North and East Devon Health Authority area of South West England.

Outcome measures .Qualitative data was analysed thematically (perceptions of service providers, sources of advice and guidance, barriers to service use). Quantative data was used to build up a picture of teenage sexual activity and sevice use. The controlled trial used the proportion of registered teenagers obtaining contraception as its outcome, with an aim to increase this by 10%.

Results The qualitative data confirmed that many sexually active teenagers are not regularly using contraception in the project area and that serious barriers exist that impede access to contraceptive services. These are explored. The controlled trail results showed that the proportion of teenagers obtaining contraceptive services was higher overall in case as compared to control practices (an increase of 2.03% against a decrease of 2.22% in control practices), however the target of a 10% increase in contraceptive provision was not met. Case practices showed very great variation in the numbers attending the drop-ins. Those attending the clinics were younger (25% under 16 years) than those using normal GP services and 42% had not previously attended any service.

Conclusions . Most teenagers obtain contraceptive services from general practice (especially in rural areas) but issues such as transport, confidentiality and anonymity should be addressed to improve access. This is crucial if government targets to reduce the high rates of teenage pregnancy in the UK are to be achieved.
A weekly, hour long nurse-run drop-in sexual health service for teenagers in general practice produced a small increase in the proportion of teenagers obtaining contraception and was popular among teenagers and staff. Longer opening times and other locations might further improve effectiveness

MD Thesis

Dr Richard Ayres

Drop-in clinics for teenagers in Primary Care: a study to determine their acceptability, effectiveness and cost

Background to this project

This project grew out of a particular experience, which largely shaped its development. I was a GP in a Devon practice, and was called one Saturday afternoon to see a fifteen year old girl with abdominal pain. The address was a council house in one of the poorer parts of town. The family was in the front room, and the girl's mother showed me upstairs. The patient was very young looking and pretty. She was lying in bed, apparently fully clothed. She was sweating and looked frightened, but claimed to be "alright" when I enquired about her symptoms. It did not take a great deal of examination to ascertain that she was pregnant, and indeed quite near to delivery. Fortunately the practice midwife lived nearby and a phone call brought her just in time to help me to deliver a healthy baby boy. The patient and her mother denied all previous knowledge of the pregnancy.

I found this case really challenging. How could this young girl have gone through her entire pregnancy alone and without telling anyone? Did she really not understand what had happened to her? How had she managed to hide it at school? More disturbing was a sense of responsibility. What sort of society were

we in that this young person had been too scared to ask for help; had got into this position in the first place? What sort of future would there be for her, and for the baby? Finally how did it reflect on me as a doctor, and on us as a practice that this should happen to one of our patients? Other things also contributed to my unease. Firstly the family planning clinic, which had been housed in the health centre had recently closed due to lack of funding, and I wondered what impact that was having on the availability of contraceptive services for young people. Secondly I was aware of a wider issue within our small town. Teenagers were unpopular, people complained about them "hanging around" the town square. They smoked, some took drugs. Correspondence in the local paper following an article about the closing of the only youth club had nearly all been critical of young people, bemoaning their apparent inability to use their time usefully.

This is the context in which this project developed. The focus is on teenage pregnancy, but seen as part of a wider issue of teenage sexuality and how we deal with this in our communities.

My first response was to look at the literature related to teenage pregnancy in the UK and particularly at service provision for teenage sexual health needs. The results are presented in chapter 1. The experience of my patient was unfortunately a common one in Britain, where teenage pregnancy rates are higher than any other western European country. This seemed principally to relate to poor contraceptive use. I looked at the records from the (now closed) family planning clinic and found that very few young people had attended in any case (no person 16 years or younger had attended in the year prior to closure). I then looked at our practice records for teenage sexual health consultations and contraceptive services. Numbers were very low, and I wondered what the barriers were for young people wishing to obtain contraceptive services in our community. The literature suggested that an informal drop-in style of service provision was popular with teenagers, and I resolved to try this out in the practice. This pilot project became the inspiration for the much bigger project described in this thesis. I was fortunate to have a sympathetic colleague in the other practice serving the town, and we were able to establish a clinic serving both practices. How we did this is described at the

end of chapter 1. The apparent success of the pilot project made me wonder whether this model of service provision would work elsewhere. If so then perhaps General Practice based drop-in clinics everywhere might prevent experiences such as that of my young patient and reduce teenage pregnancy rates. I discussed these ideas widely and was lucky enough to be put in contact with the Institute of Population Studies at the University of Exeter. The director, Dr Chris Allison was interested and willing to help and advise on research aspects. I had worked closely with the North and East Devon Health Authority in looking at the funding aspects of the pilot project drop-in service and in developing protocols for the nurse led service. Dr Mike Owen (now director of public health for the authority) and Dr Virginia Pearson (now director of public health for Somerset) were also interested and together we finally obtained funding for the project via a South-West Regional "Developments in the Organisation of Care" grant. This provided funding for 3 years, starting in 1997. Dr Allison moved on and left the project in April 1998. Dr Owen and Dr Pearson have continued to be part of the research team. We were fortunate to recruit a research assistant, Ruth Garside from the Institute of Population Studies who did much of the administrative work and moderated the Focus Group Discussions.

Acknowledgements

I wish to record my gratitude to Mike Owen, Virginia Pearson and Ruth Garside for all their hard work, inspiration and guidance, and to my adviser, Dr Anna Glasier for constructive criticism of this project.

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Dedication

This thesis is dedicated to an unnamed teenager (now a young adult) who made me question whether we could do better for young people

CHAPTER ONE
TEENAGE PREGNANCY

Chapter summary

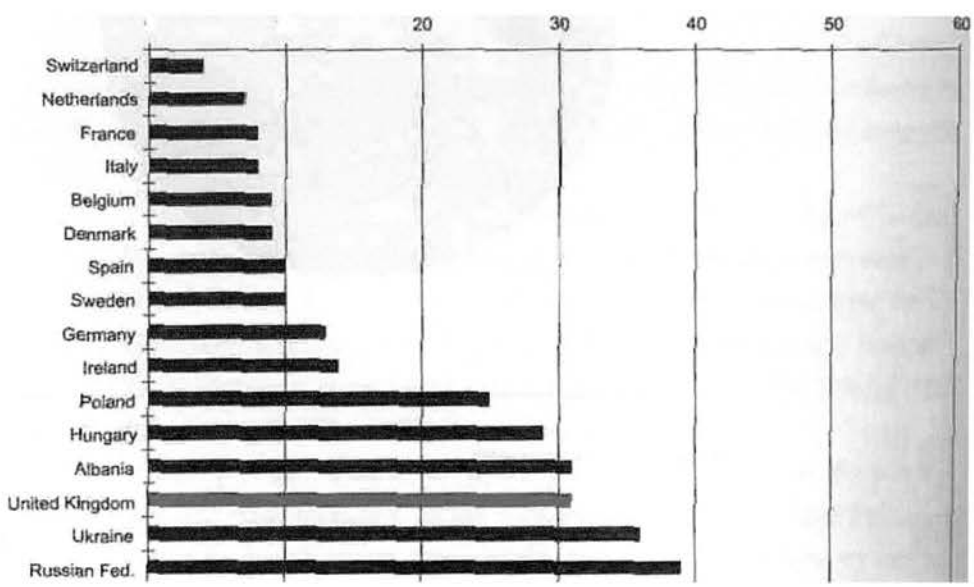
In this chapter I will review the literature regarding teenage pregnancy in the UK (setting it also in an international context). I shall look at what is known about the sort of services that teenagers prefer, how they use general practice for sexual health purposes and in particular the place of dedicated drop-in services to provide for their needs. Finally, I shall describe the setting up of an apparently successful teenage drop-in service in my own practice. This served as the inspiration and pilot for the study described in this thesis. The chapter ends with an outline of the study itself.

Literature Review

Britain has the highest teenage conception rate and the highest teenage birth rate in Western Europe.[1] This has not always been so. In the 1970s the UK had similar teenage birth rates to other European countries, but whilst rates in the rest of Europe fell dramatically in the 1980s and 1990s, those here remained almost static. The teenage birth rate in the UK is now twice as high as in Germany, three times as high as in France and six times as high as in the Netherlands.[2] **Figure 1** below illustrates that the UK is in a league together with former Eastern European countries rather than with more developed countries such as France and Germany.

Figure 1 *Source: Gupta (1998)*

Births per thousand young women aged 15-19 in European countries, 1996



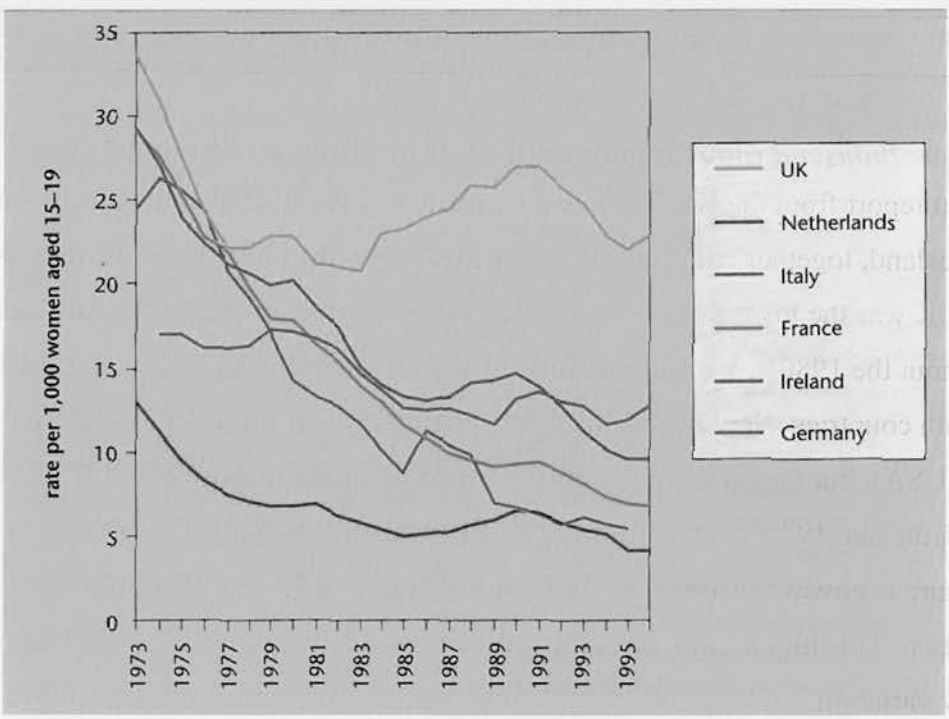
A recent paper from the Alan Guttmacher Institute in New York[3] examined levels of teenage pregnancy and childbearing within industrialised countries in the mid 1990's, as well as trends over recent decades. They found a huge range of teenage birth rates, from a low of 4 per 1000 (age 15-19) in Japan to a high of 56 per 1000 in Armenia. It was possible to discern 3 broad bands:

- Low rates. Japan and most of Western Europe;
- Moderate rates. Eastern and Central Europe, Australia and New Zealand plus Britain and Iceland;
- High rates. Eastern Europe, Russia and the United States.

Because of variable reporting of abortion statistics, pregnancy rates were considered less accurate for some countries, but they broadly showed the same pattern.

Looking at the trends over the last 25 years, with the exception of 8 countries in Eastern Europe, rates have fallen over the whole period. In 18 countries the rate was more than halved during the period 1970 – 1995, and the reduction was often much greater. The timing of the decline varies, and the UK is distinguished by a levelling out of the decline at the beginning of the 1980's, while rates in the rest of Western Europe continued to fall. This is illustrated for live births in **figure 2** below (source: Eurostat)

Figure 2: Live birth rate to women aged 15-19: various European countries



Trends for teenage conceptions over the ten years 1987-1997 for England and Wales are illustrated in **figure 3** below and show little decline over that period:

Figure 3 Teenage conceptions (number and rates) by age of conception, England and Wales 1987-97 FM1 series ONS

Age at year conception	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997
Rate per 1000	*1.0*	0.9	0.8	1.2	1.1	1.2	1.2	1.3	1.2	1.5	1.2
14 Total conceptions	1,777	1,652	1,650	1,754	1,686	1,632	1,774	1,938	1,834	1,961	1,964
Rate per 1000	5.4	5.4	5.5	6.1	6.1	5.8	5.8	6.1	5.8	6.3	6.3
15 Total conceptions	6,538	6,336	6,077	6,069	5,476	5,222	5,125	5,460	5,835	6,445	5,942
Rate per 1000	18.7	19.3	19.7	20.3	19.7	19.0	18.3	17.9	18.4	20.4	19.2
Subtotal: Total conceptions under 16	8,627	8,258	7,950	8,139	7,480	7,217	7,267	7,795	8,051	8,857	8,271
Rate *per 1000*	*8.8*	*8.8*	8.9	9.5	8.9	8.4	*8.1*	8.3	8.6	9.5	8.9
16 Total conceptions	16,112	15,395	14,703	13,923	12,623	11,932	11,031	11,336	12,382	14,284	14,058
Rate per 1000	43.3	43.9	44.6	45.7	42.7	47.5	40.7	40.5	40.6	45.0	44.5
17 Total conceptions	24,441	25,088	23,817	22,694	19,985	18,403	17,504	16,960	17,447	20,349	21,029
Rate per 1000	66.4	67.2	67.6	68.4	64.2	61.4	60.9	61.6	62.1	66.6	66.1
18 Total conceptions	33,367	31,957	32,414	31,183	27,851	25,218	23,422	22,614	22,402	24,150	25,618
Rate *per 1000*	87.0	86.7	86.8	88.4	83.6	80.9	78.0	78.5	81.0	85.7	83.6
19 Total conceptions	38,790	38,200	36,843	37,391	33,686	30,648	27,949	26,647	26,305	27,233	27,031
Rate *per 1000*	99.9	99.3	99.6	99.9	94.9	91.7	89.4	88.4	90.8	97.9	95.4

A recent report from the Health Education Authority has looked at data from Australia and New Zealand, together with Canada and the USA.[4] In the mid 1970's the teenage birth rate in the UK was the lowest of all 4 countries. However rates in Australia and Canada fell throughout the 1980's, whilst those in the UK increased slightly. We now have higher rates than both countries. New Zealand had very high rates in the mid 1970's (similar to those for the USA), but they fell rapidly during the 1980's (unlike those of the USA which rose through the late 1980's and early 1990's). They are now slightly above those of the UK. The figure is however skewed by the high rates (around 82 per 1000) of the Maori population. This highlights a common theme from many studies; the very wide *within* country variation.

This may be related to race, such as the New Zealand Maoris, or the Aborigines in Australia (who have rates of over 160 per 1000); or to region. In 1996 the teenage pregnancy rate in the USA ranged from 42 per 1000 in N Dakota to 121 per 1000 in Nevada[3]. Such variations exist in the UK at District Health Authority level (in 1996 rates in Lambeth, Southwark and Lewisham were 104 per 1000, whilst those in Kingston and Richmond were 34 per 1000[5]) and right down to Ward level (a study in the S West of England[6] found rates varying from 0 to 160 per 1000 between Wards).

It is widely considered that such high figures for teenage pregnancy in the UK are a bad thing, and with good reason. Babies born to teenagers are more likely to be premature, small for gestational age, or have low birth weight[6].Teenage mothers are more likely to experience pregnancy complications[7] [8]and to feel depressed and isolated[9] than older mothers. Perhaps more importantly teenage mothers are more likely to lose out on education[10] and employment opportunities[11] and suffer poor housing and nutrition.[12] Their children are more likely to be hospitalised due to accidents[13], to have developmental delay[14] and to live in poverty.[6]
Finally they are more likely to become teenage mothers themselves[15], thus perpetuating a cycle of deprivation.
Teenage sexual activity itself carries risks. The incidence of sexually transmitted diseases among teenagers is rising rapidly. Figures from the Public Health Laboratory Service[16] show increases between 1997 and 1998 of 52% in Gonorrhoea amongst males 16 –19, and 39% amongst females. There have also been sharp increases in the number of chlamydia and genital wart infections amongst teenagers[17]. Moreover the incidence of Cervical carcinoma is increasing and it is presenting at a younger age. The risk is directly linked to age at first intercourse and to the number of sexual partners[18].

However the most compelling argument of all is that most teenage pregnancies are not planned, and are regretted by the teenagers themselves. Half of all pregnancies in under 16s are terminated and more than a third in teenagers 15-19. In a study of teenagers (average age 17 years), attending either for termination of pregnancy or antenatal care in Devon, 73% said that they had not intended to become pregnant.[19]. Sexual activity itself is often regretted by teenagers and felt to have happened too early, especially in those starting before the age of 16[20] [21].

Successive UK governments have tried to address the issue of teenage pregnancy. In 1992 the Conservative administration produced the Health of the Nation strategy for England and Wales.[22] This identified prevention of pregnancy in young teenagers under 16 as a priority, and set a target of reducing the rate from 9.6 per 1000 in 1989 to 4.8 per 1000 by the year 2000. This target, as we shall see later has not been met, or even approached. In 1999 the Labour government, through its Social Exclusion Unit produced a comprehensive action plan.[23] This has a new target, to half the rate of conceptions among the under 18's by 2010. (The remit of the unit is only for England, but the underlying analysis and the priority given to tackling the problem is said to be shared also in Scotland, Wales and Northern Ireland). The document containing the action plan includes considerable discussion about the possible reasons for the high rates in this country. Unlike previous government publications it acknowledges the link with poverty. Research in the USA[24] (where teenage pregnancy rates are considerably higher than in Britain) has identified a range of antecedents predictive of high risk for teenage conception:

- community disadvantage (levels of unemployment, crime etc in local community);
- involvement in other risk taking behaviour (alcohol, drug use etc);
- no attachment to religious institutions;
- poor success at and attachment to school;
- family structure, parental beliefs and communication about sexuality;
- early puberty, sexual abuse and emotional distress;

A multivariate analysis of international data[25] found that some general characteristics about a country correlated with low teenage birth rates:

high GDP per capita;	Government policy to provide contraceptives to the young
favourable income distribution;	openness about sex
high % of women taught about contraception	high minimum age at marriage

A recent study in the South and West of England[26] used a variety of indices of social deprivation to explain the variation in teenage pregnancy rates in the former Wessex region. They found that the factors that correlated best with high rates differed in urban and rural areas. Factors were:

Urban areas;	Rural areas
• High proportion of children under 5 years;	• overcrowding;
• high proportion of households without access to a car;	• Lack of basic amenities;
• high percentage of 17-year-old children not in full time education;	• High proportion of children under 5 years
• high population mobility.	• Non-car-ownership

These links with socio-economic factors are interesting and indeed (for a government said to be committed to action on teenage pregnancy) challenging. However they do not indicate

what the behaviour underlying the problem is, and why we seem to do so much worse than our European neighbours.

Looked at simply there are two possible reasons why teenage conception rates might vary, both between and within countries:

- Differing levels of sexual activity amongst teenagers.
- Variability in the use of contraception.

In addition the teenage birth rate will be influenced by the abortion ratio (the percentage of pregnancies that end in abortion). I will consider these three possibilities in reverse order.

Abortion Ratios

The abortion ratio in Britain is fairly low as judged by other European countries (see **Figure 4** below. (Source UN demographic yearbook 1996)

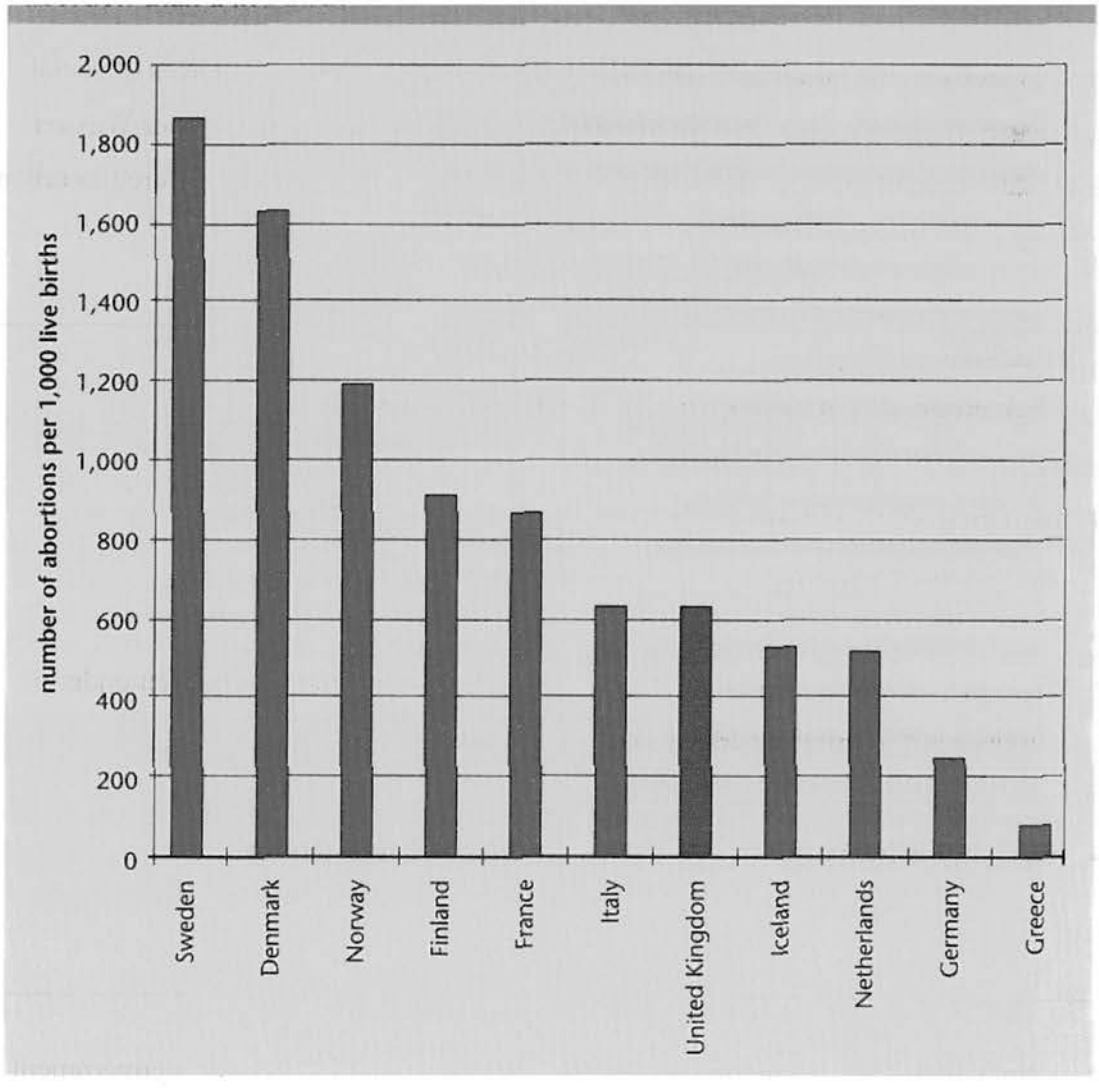
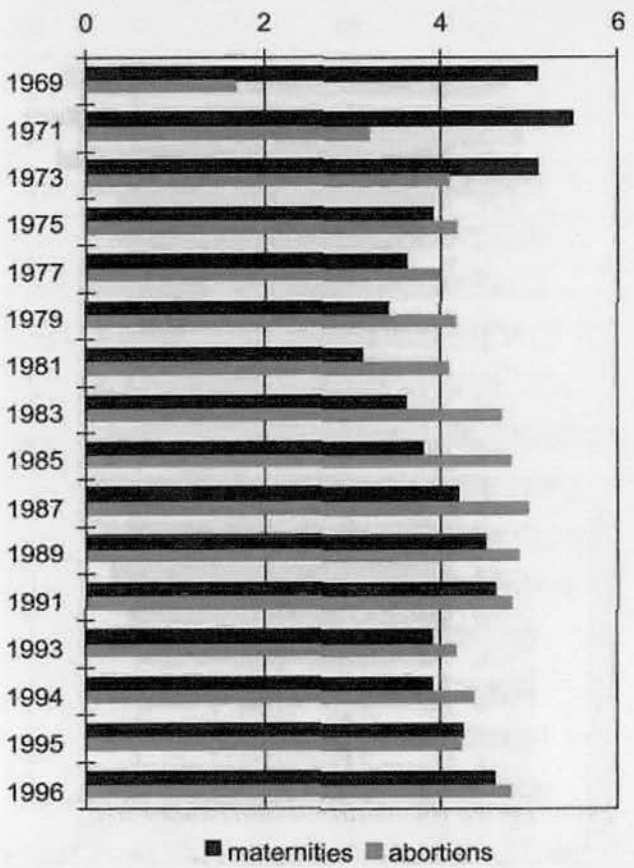


Figure 4: Abortions per 1000 live births (women < 20). 1994, or latest available year.

Outcome of pregnancy varies with age. Conceptions leading to maternity among 13-15 year olds have decreased since 1969 in England and Wales, with an increase in the number of abortions (see **figure 5**). The main change occurred in the early 1970's, following the introduction of the 1967 abortion act. In 1996 almost 50% of conceptions in this age group led to abortion.[27]

Figure 5: Rates of maternities and abortions in England and Wales among 13-15 year olds, 1969-1996 Rate per 1000 females



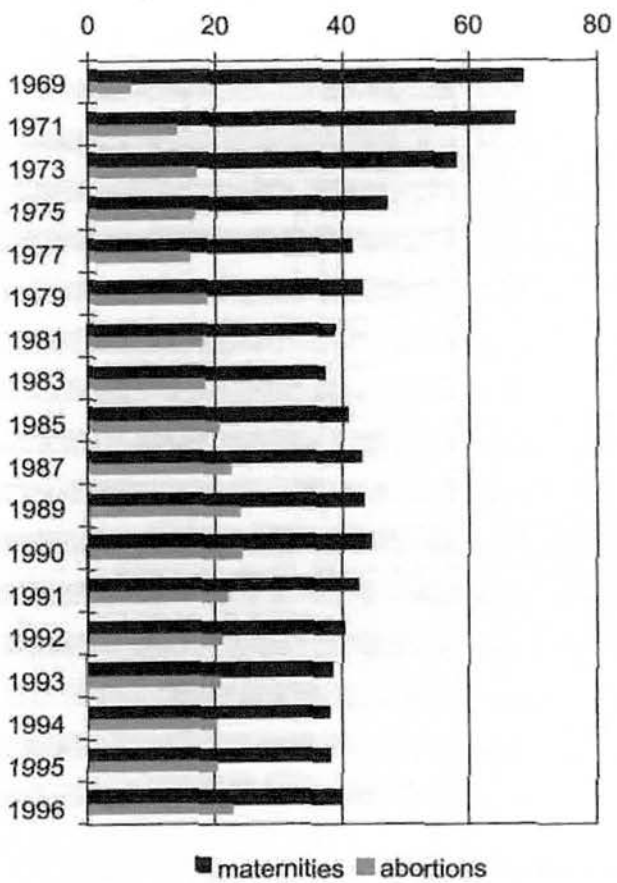
Source: conceptions in England and Wales 1996. Office for National Statistics Monitor FM1

In the 15-19 age group, maternities have fallen, whilst abortions have increased steadily from the early 1970's (**figure 6**)

Figure 6: Rates of maternities and abortions among women 15-19 in England and Wales,

1969-1996

Rates per 1000 females



Source: Conceptions in England and Wales 1996. Office for National Statistics FM1

The abortion ratio is however lower in this age group, with 37% of conceptions ending in abortion in 1996[5].

A study looking at trends in adolescent pregnancy and childbearing across developed countries[3] concluded that abortion is not an important factor in explaining recent trends in adolescent birth rates. Rates had changed little in the countries studied, despite very big

changes in birth rates. The same point is made elsewhere[28] in relation to Denmark and the Netherlands. We must therefore look elsewhere to find the reasons for differing levels of teenage conception across Europe

Levels of teenage sexual activity

International comparisons show a clear trend toward earlier age of sexual initiation across the developed world. A study in 11 countries across Europe[29] showed that median age at first intercourse has fallen in all countries by at least two years since the 1950's. There has however been great variability in the timing, with Iceland and the Nordic countries forming a first "wave" starting in the late 1950's, followed in the 1960's by France, Germany and the UK. Switzerland, Belgium and some Southern European countries such as Greece and Portugal form a "late" wave

.

Within this overall picture there are interesting differences. In all countries men have an earlier age of sexual debut, but this has narrowed over the period studied; that is, much of the change has resulted from a lowering of the age at first intercourse among women. The Nordic countries are much more egalitarian in this regard with an early, sharp fall in age in women resulting in equality (at a median age of 17 years). Indeed there is some evidence that a crossover has occurred, with more women than men having first intercourse before age 18.[30] Southern European countries such as Greece and Portugal show a "double standard" with men starting their sexual career two years earlier on average than women.

In Britain the progressive fall in age at first intercourse has been well documented in the National Survey of Sexual Attitudes and Lifestyle[31](Natsal). Cohorts of different aged respondents were asked when they had their first experience of sexual intercourse. Looking at the figures for those having intercourse before the age of 16 there is a progressive rise with decreasing age (**table 1)** overleaf. Natsal 2000 has recently been reported[32]and suggests that this trend continued through the early nineties, but that interestingly, there appears to have been a stabilisation of age at first intercourse among women starting later in the decade.

Table 1: First sexual intercourse before the age of 16 by current age

Age at Interview	Males		Females	
	%	Base	%	Base
16-19	27.6	827	18.7	971
20-24	23.8	1137	14.7	1251
25-29	23.8	1126	10.0	1519
30-34	23.2	1012	8.6	1349
35-39	18.4	982	5.8	1261
40-44	14.5	1042	4.3	1277
45-49	13.9	827	3.4	1071
50-54	8.9	684	1.4	933
55-59	5.8	603	0.8	716

Source Johnson et al. (1994)

The same data shows that nearly 90% of women born in 1971 had sexual intercourse before the age of 20, compared with fewer than 30% born in 1931. The sharpest increase is in women born in the decade following the Second World War, who were in their teens in the 1960's. The median age at first intercourse fell by 4 years for women and three years for men over the last 4 decades, standing at 17 years for both men and women aged 16 – 19 at the time of the interview.

Overall it seems that whilst Britain has experienced the same profound decrease in the age of onset for sexual activity as the rest of Western Europe, there is little evidence to suggest much difference in teenage sexual activity rates. Indeed it seems that some countries such as Denmark and Sweden[33] have higher rates than the UK, but with much lower teenage conception rates. The mean ages quoted for sexual debut however conceal big variations. Taking the percentages of 16-year-olds that report having had sexual intercourse, studies in the S West of England have shown figures ranging from 23% of males and 25% of females, to 74% and 49% respectively[34]. There is some suggestion that the proportion of

very young (15 or under) women having sexual intercourse is higher in Britain than in the Netherlands[35]. Surveys in Scotland[36] showed a significant increase in the proportion of 15-year-olds reporting sexual intercourse between 1990 and 1998. Also in Scotland a school-based survey in 1996/7[37] found that from a sample of pupils with a mean age of 14 years and two months, 18% of boys and 15.4% of girls had experienced intercourse. Less scientific, but still informative are the results of a lifestyle survey in "sugar" magazine, which has a reported average reader age of 14.4 years. Of 746 girls responding in 1999 to the survey, 17% reported that they had had sex. Of these 28% reported that first sex happened at 13 years or younger. The average age was 14.5 years.[38]. Overall however, there is no evidence that higher levels of sexual activity amongst UK teenagers offer an explanation for the increased numbers of conceptions compared to other countries.

Use of contraception

Use of contraception by sexually active teenagers is low in the UK compared with other European countries. This was highlighted in the international study quoted above[4], which also commented on the very low rate of use in what they term "early starters" (first intercourse before 16 years). **Table 2** below illustrates some available figures.

Table 2: Proportion of adolescents using contraception at first intercourse

Netherlands	85 per cent	("young people")
Denmark	80 per cent	(15–16s)
Switzerland	80 per cent	("adolescents")
US	78 per cent	("adolescents")
France	74 per cent	(girls; 79 per cent boys (condom use))
New Zealand	75 per cent	(sexually active teenagers)
UK	50 per cent	(under 16s); 66 per cent (16–19s)

Source: Teenage Pregnancy, Social Exclusion Unit 1999

The figure in this government publication of 50% of under 16's having used no contraception is particularly alarming. A high rate of non-use of contraception at first intercourse is certainly borne out by other studies in the UK, but rates are not quite so high. A survey in Southampton[39] of clients attending young peoples clinics found that 17% of attenders had not used any contraception at first intercourse, and 46% of non-virgin teenagers had had unprotected intercourse at least "a few" times. An earlier study done as part of the "A Pause" project in Exeter[40] suggested that those teenagers who had sex before 16 years were almost twice as likely to have had sex at some time without using contraception. More recently in the Durex Global Sex Survey, 68% of UK 16-21 year olds reported using a condom at first intercourse, and 16% some other method, but 16% used no protection. A further Durex survey in 1999, based on a sample of over 8000 16-55 year olds found that 19% of 16-17 year olds and 17% of 18-20 year olds reported having had unprotected sex with a new partner. This was an increase from 13% and 15% respectively on the 1998 survey. In 1996/97 a survey in Scotland[20] among very young teenagers (average age 14 years and 2 months) found that 60.2% reported using a condom at first intercourse, 18.9% no contraception and 8.9% "withdrawal". In the "sugar" magazine survey 54% of sexually active girls reported having unprotected sex at least once.

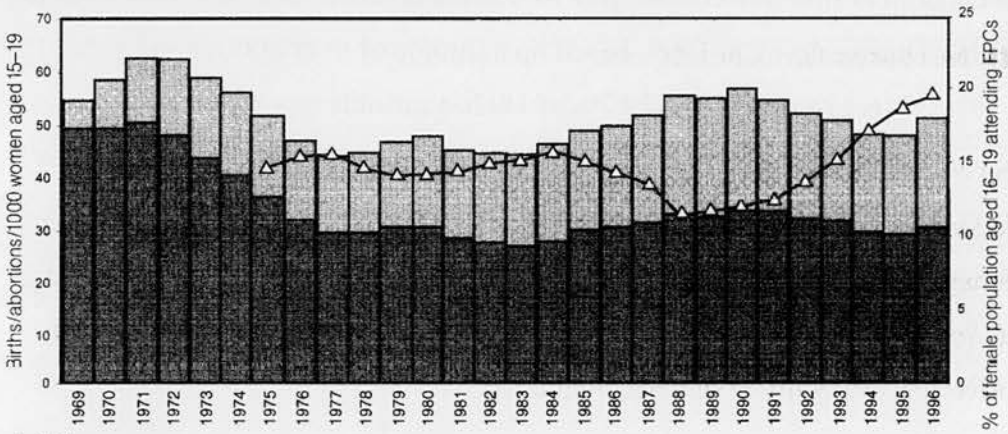
From these studies it seems clear that many teenagers in Britain do not use any form of contraception at first intercourse, with the youngest being least likely to do so. A much higher proportion (probably more than 50%) of sexually active teenagers fail to use contraception at least sometimes. This is in line with an American study[41] suggesting that whilst in the USA use of contraception at first intercourse is increasing, its use at *most recent* sex may be declining. Despite this, teenage pregnancy rates in America, which are extremely high, have fallen over the last 10 years. A 1999 report[42] noted that pregnancy rates in 15-19 year old women were 117 per 1000 in 1990, but fell by 17% over the next 6 years to 97 per 1000 (the UK figure for 1996 was 63.3 per 1000). Detailed analysis of this change has suggested that at least three-quarters is accounted for by reduced conception rates secondary to contraceptive use.

Further evidence that the use or non-use of contraception by teenagers is the principle determinant of teenage conception rates comes from a UK study[43] in which data on teenage

conception rates was compared with information on teenage sexual activity rates and use of family planning clinics. Conception rates were calculated from birth and abortion statistics, information on sexual activity obtained from the National Survey of Sexual Attitudes and Lifestyles, and use of family planning clinics from routinely collected data. Trends in family planning service use by teenagers over the study period mirror trends in teenage pregnancy with increases in attendance corresponding with decreases in the teenage birth and abortion rate and vice versa.

This is illustrated in **Figure 7** below:

Figure 7 Teenage birth and abortion rates and family planning clinic (FPC) attendance, England and Wales 1969-1996



[Sources: Birth statistics:
Series FM 1 (ONS); Abortion statistics: Series AB (ONS);
Department of Health Family Planning Clinic Services. Summary Information for 1996-7, England (1998); Health Statistics (1998) Welsh Office]

Live birth rate ■

abortion rate □

percentage of women attending FPCs △

Moreover it was also demonstrated that there was an increase in the teenage birth rate following each of the media "scares" about adverse effects from the pill in 1977, 1983 and 1995, an effect which persisted for up to 3 years[44 45]. The same thing happened after the widely publicised legal case brought against the DHSS by Mrs Victoria Gillick in 1985. Despite her action being defeated in the House of Lords, the case generated suspicion amongst teenagers about confidentiality, and attendance rates for teenagers at family

planning clinics fell. This was followed by an increase in the teenage conception rate (see figure 7 above). There was no change in the level of teenage sexual activity.

Overall, because of the steady and consistent increase in the rate of teenage sexual activity over the past four decades, the teenage fertility rate has actually been falling for most of this time, when calculated against the denominator of sexually active women (rather than the total sample of teenage women). There seems little doubt that the variations in teenage pregnancy rates both within and between developed countries are due principally to variations in contraceptive use, with perhaps some contribution from variation in the age of sexual debut.

Sexual Health Services for Teenagers.

It is a department of health requirement that district health authorities and primary care services provide family planning services that are responsive to the needs of the population served.[46] For teenagers quite a lot is known about what they want. Allen[47] in her study of a range of projects funded by the department of health identified the following factors that made contraceptive services more or less acceptable:

- convenient opening times
- embarrassment from being seen by other people while seeking sexual health advice
- not feeling comfortable with staff
- fears about confidentiality
- having to give personal details.

She concluded that teenagers prefer separate services set up especially for them in premises designed to meet their needs. She noted that confidentiality was a key concern for many and indeed "the single most important factor in designing services for young people".

Aggleton[48] in 1996 produced a compendium of services that he felt were most appropriate for young people. He suggested that these should be available via;

- Specialist clinics

- GP's
- Youth advisory services
- Community based outreach work

He also suggested that the range of services should include;

- condom provision
- emergency contraception
- dual methods (protection against STD's as well as pregnancy)
- smear tests
- on the spot pregnancy testing
- advice and referral for termination of pregnancy
- STD testing and referral to specialist services.

A literature review and survey of 177 providers of sexual health services for young people by Peckham et al[49], whilst noting that there were few methodologically rigorous studies on effectiveness, produced further recommendations;

- no appointment necessary / drop-in
- convenient opening times and location
- provision of advice on any health problem
- confidential service
- female staff available including doctors
- an informal and friendly setting
- openness to going with friends
- telephone advice available

A more recent overview[50]by the HEA suggested that service provision could be improved within traditional settings, but recommended expansion to include dedicated young people's services meeting local needs.

Contraceptive advice has been available on the NHS free of charge to everyone in the UK since 1974, emergency contraception since 1984 and termination of pregnancy (providing certain conditions are met, and with the signature of two doctors) since the passing of the

1967 abortion act. In theory such services are available for teenagers at any GP surgery, at Family Planning Clinics and within dedicated clinics such as Brook centres. More recently some GUM clinics have started to offer these services. In practice however choices can be limited. GP services and Family Planning clinics are by far the biggest providers, and whilst government policy has continued to support the provision of both services, funding arrangements have disadvantaged the latter. GP's are financed from open-ended central budgets, whereas the clinics are paid for out of cash limited District Health Authorities local budgets. As a result many Family Planning clinics have closed (including the one in S Molton where this work started). Between 1978 and 1989 the number of FPC sessions fell from 204,100 to 190,900, and the proportion of services provided in clinics fell from 56% in 1976 to 30% in 1989[51]. Overall since 1991 at least 70% of contraceptive services have been provided by GP's.

Teenage pregnancy and General Practice

Teenagers attend their General Practice on average two or three times a year[52]. By the age of 15 over 50% of boys and just under 60% of girls attend by themselves.[53] They consider their doctors surgeries to be the most appropriate place to receive health care and they trust their doctors for health related information.[54] A study by McPherson et al[55] of 17-year olds found that the things that they rated as most important in primary care facilities were; first confidentiality; second, anonymous access to advice via the telephone; and third, good written information. In a questionnaire- based survey in N London[56] 76% of 12-18 year olds said that they would like a drop-in service in their practice. It has been recommended[57] that practices should take action on the basis of these findings. Firstly they should define the characteristics of their teenage population (employment rates, number of single mothers etc). Secondly they should advertise to all registered teenagers that they can register independently with a different GP from their parents and that they can be assured of absolute confidentiality. They should also be given details of specific services such as the provision of emergency contraception. Thirdly teenagers should be involved in making practices more user friendly for young people by provision of appropriate facilities, posters etc. Fourthly practice staff should be trained to be more responsive to the needs of

teenagers (including providing a friendly response to teenagers reluctant to give their names or details of their problem on the phone). Finally written information about the practice should be available in a format orientated toward young people.

Despite such advice there is evidence of problems in provision of care for teenagers in General Practice. A survey in Hertfordshire[58] found that fewer than 20% of responding practices provided any special services for teenagers. GPs in another study[59] gave less time per consultation to teenagers than to any other group. In a study of 40 GPs from 60 practices across England and Wales[60] 5 practices said they were unhappy or uneasy about providing contraception to under 16s, and 11 GPs said that they preferred to involve the young persons parents. One GP is quoted as saying "I usually send them away with a flea in their ear and ask them to bring their parents". No practice provided special services for teenagers.

As part of the research project described in this thesis we conducted a questionnaire survey of GPs attitudes toward sexual activity in the under 16s[61]. A small proportion (6.5%) disagreed with a statement that they owed the same duty of confidentiality to under 16s as to other patients. However 70% of GPs said that they would prefer parents to know when a sexually active under sixteen year old had consulted them for advice, and 76% if contraception was provided. A small proportion believed that by providing contraception to under 16s, they were aiding a criminal act, and about a third would try and persuade under 16s to wait until they were older before having sex. Such attitudes amongst GPs are very likely to be picked up by teenagers and may well constitute a barrier to consultation for contraception by young teenagers.

Teenagers have also been found to have difficulties in accessing GP services. In the survey from N London quoted above[56] 61% of teenagers said that they would not know how to register with a GP when they left home, and 40% said that they had found it difficult to see their GP for various reasons (reasons given were difficulties getting a quick appointment 50%, embarrassment 59%, unsympathetic GP 34% and concerns that parents would find out 29%). Burack[62] in a questionnaire study of 13-15 year olds in Barking and Havering found that 54% believed that they had to be over 16 years old to access sexual health services although most (68%) were aware of sexual health services offered by GPs.

Confidentiality is a key concern for young people needing to access sexual health services. Allen[63] described confidentiality as "the single most important factor in designing services for young people" (page 302). In the study by Burack mentioned above, over half the sample were concerned that confidentiality would not be preserved. This is a similar figure

to that obtained in another survey in 30 schools in England reported by Donavan et al[64]. A survey in Wessex[65] found that young women are less likely to see GPs for sexual health services in rural than in urban areas. The authors suggest that this may be because of greater problems with confidentiality and anonymity in small communities. Recently the Royal College of GPs and Brook have produced a "toolkit" for GPs giving practical advice on how to prevent lapses of confidentiality, both deliberate and accidental[66]. This report also reminds GPs of the guidelines on providing contraceptive advice and treatment to under 16s issued as part of Lord Fraser's judgement following the "Gillick" case in 1985. Concerns have been raised about the increasing role of General Practice in the provision of contraception to teenagers. Victoria Gillick[67]is concerned that GPs may be providing contraception to too many teenagers "whilst riding roughshod over the legitimate rights and responsibilities of parents". In view of the huge problem of teenage pregnancy in the UK more important are concerns that GPs may be less effective than family planning clinics in doing this job. Allaby[68]looked at the ratio of conception rate: uptake of contraceptive services in 8 health districts of the former Oxford region. He considered that a low value suggested effective contraceptive services, and found that it was lowest in districts where family planning clinic attenders comprised a large percentage of all users of contraceptive services. He concluded that contraceptive services for teenagers may be less effective in areas where GPs play a large part in delivering services. Allaby does not suggest why GPs should be less effective than Family Planning clinics, other than quoting Allens' finding that teenagers regard confidentiality and a friendly reception as the most important qualities of a service: qualities which may be less easily found in general practice. However Seamark and Gray[69]contest Allens' findings. In a study of two quite different Devon practices they found that over half of the registered 16-19 year old girls had consulted regarding contraception. They concluded that most sexually active girls in the practice areas were receiving contraceptive advice within general practice. Two other studies in Devon[70 71] also found a high level of satisfaction with GP services, but highlighted some differences between contraceptive services provided by GPs and by family planning clinics. Clinics were three times more likely to offer drop-in services and much more likely to offer free condoms. Clinics also offered a wider range of contraceptive methods whilst GPs mostly prescribed the oral contraceptive pill.
The characteristics of individual practices may also influence teenage access to contraceptive services. A study from Trent using data from 826 practices[72] found an association between teenage conception rates and the age and sex of GPs in practices as

well as with availability of practice nurse time. Practices with a female partner had 91% of the teenage pregnancy rate found in other practices; practices with a doctor under 36 years had 84% of the rate and practices with both a female and a young doctor had 75% of the teenage pregnancy rate. Practices with more practice nurse time also had significantly lower rates than did those with less. These differences persisted when corrected for variables such as deprivation. Distance of a practice from a family planning clinic had no significant effect. The authors suggest that since general practice is now by far the largest provider of sexual health services to teenagers these associations are causal. A comment published with this study even suggests that practices in areas of high teenage pregnancy should consider these findings when recruiting medical and nursing staff.
To summarise:

- General Practice provides 70 –80% of sexual health services to teenagers;

- The proportion is likely to grow given current funding arrangements. However practices are not paid for services to male teenagers, who attend all forms of service much less frequently than females.

- Despite recommendations from the Department of Health and Brook that special clinics should be provided for teenagers and evidence that they prefer this; very few practices provide such services.

- There are several barriers to access by teenagers to sexual health services in General Practice. Confidentiality and anonymity are seen as most important by young people themselves, and may be a bigger problem in rural areas. Some GPs disapprove of sexual activity in young teenagers and young people quite often report unhelpful attitudes by GPs and also by receptionists.

- Whilst it may be true that most teenagers do consult GPs about contraception, many still become pregnant. It is possible that family planning clinics provide better advice on using contraception effectively. They also provide a broader range of contraceptive methods, as well as free condoms that are not available in general practice.

- There is some evidence that certain individual practice characteristics, by improving sexual health service provision to teenagers may reduce teenage conception rates. This underlines the crucial role of primary care in the achievement of targets to reduce rates nationally.

Drop- in clinics in General Practice

Isobel Allen's study in 1986[47] suggested that teenagers prefer separate clinics. However none of those that she studied were based in General Practice, and not all provided drop-in services. There certainly seems to be a demand for additional family planning services in primary care. One practice that advertised its family planning services to all (including patients not registered with the practice) trebled its income from contraceptive services by running an additional clinic one evening per week[73].The survey by Cooper of General Practice family planning provision in Wessex mentioned above[65]however found that there was no great enthusiasm among GP's for the provision of drop-in services. More positively an evaluation commissioned by Buckinghamshire Health Authority of a young peoples drop-in clinic based in a Health Centre in Milton Keynes[74]suggested that the clinic was popular with doctors, teenagers and parents. It did not however attempt to evaluate how effective the clinic had been in increasing contraceptive use by young people. An attempt was made to do this in an evaluation of a health centre based drop-in service for teenagers in Nottingham[75]. Perhaps not surprisingly the evaluation failed to demonstrate a fall in the teenage pregnancy rate as a result of the clinic (numbers of teenage pregnancies in a population are relatively low and the teenage population very mobile so it is notoriously difficult to use teen pregnancy rates to demonstrate an effective intervention). However it did find that the clinic provided contraceptive care for over 1400 sexually active teenage women, or 7% of the teenage female population over the evaluation period. Finally the TAC-1 project in Boston (UK) managed over time to attract around 20 teenagers a week to a dedicated young persons clinic in general practice[76]. This provided general health as well as contraceptive advice.

Summary of Literature Review

- Teenage conception rates in the UK are higher than in most of our European neighbours.
- This difference is mostly due to lower use of contraception by UK teenagers
- Young people in Britain have difficulty in accessing contraceptive services.
- General practice is a major provider of such services
- Dedicated teenage drop-in clinics may well be more acceptable to young people than traditional general practice services.

This is the context in which this study was conducted. I shall now describe the initial drop-in service that I set up, and then the wider project that arose from it.

The South Molton Pilot Project

South Molton is a small N Devon market town where I was working as a GP at the start of this project. The drop-in clinic that we set up there became both the inspiration and the model for the larger project described in this thesis. I will therefore describe the process that we went through in some detail.

There are two general practice surgeries in South Molton, with adjoining premises. Between them they provide care for the town and a large surrounding area of countryside. As a first step to improving access for teenagers to sexual health services I convened a meeting of both practices. I was aware of the literature suggesting that separate, tailored services for teenagers might improve care, but it soon became clear that we needed input from young people themselves. Myself and a female doctor from the next door practice were mandated to approach teenagers and seek their views.

We were very fortunate in contacting a youth worker from the social services department who had set up a club for young people in S Molton, and also in getting full co-operation from the deputy head of the local comprehensive school. With their help we arranged a series of meetings with groups of teenagers. These preliminary meetings were informal and they very quickly demonstrated that there was enthusiastic support for the idea of a young person's clinic. We also heard about how difficult it can be for these young people to access the services that we provided. Confidentiality was a major issue, as has been found in many other studies. Related to this, and almost more important in this rural area was

anonymity. Many young people had relatives or family friends who worked in one of the health centres and they felt that it would be very difficult to attend on their own without it getting back to parents, friends or even school teachers (this issue came up very forcefully from a variety of sources as reported in the qualitative study in chapter 3).
We felt that our initial meetings had been a success and both practices were prepared to support the setting up of a joint service for teenagers (the first time that the two practices had co-operated in providing services). We needed to know exactly what sort of service would be most acceptable, so we arranged a further series of meetings with teenagers, building on the experience and contacts that we had made. These were more defined Focus Group Discussions and we tried to include representatives of all age groups (13-18) and both practices. The main findings from these groups were:

- Appointment systems and the need to telephone and speak to a receptionist were seen as a major barrier. A drop-in service was greatly preferred.

- The clinic should be separate from the main reception and patient areas of the health centres (preferably with a separate entrance). It should be "teenage friendly" and drinks and biscuits would be a popular provision.

- A nurse run service was preferred. Most of the girls wanted a female nurse.

- A full range of services should be available including provision of the oral contraceptive pill (preferably without the need to go to the pharmacy to get a prescription which was seen as barrier), as well as condoms and pregnancy testing.

- The best times were felt to be after school or during the school lunchtime.

Following these meetings we decided to start a nurse run drop-in clinic for teenagers. We were fortunate to have enthusiastic support from two very experienced practice nurses, as well as our health visitor and one of the school nurses who was based in the health centre. The youth worker with whom we had been working also volunteered to attend and act as receptionist. The practical difficulties of holding a clinic outside of our premises altogether were felt to be too great. We decided to utilise an upstairs common room in one of the

practices. This was large and comfortable, with its own entrance, and there was a separate room where young people could be seen for counselling or physical examination. The Focus Group discussions had suggested that a once weekly clinic on a Thursday lunchtime was the most convenient for young people (principally for reasons related to the local school timetable) In a further joint practice meeting a number of problems were raised. These included the following:

1) Funding.

This is always an issue in primary care since most General Practices are essentially small businesses. We were hopeful that the clinic would generate some income through item of service payments. These are part of the remuneration system for GPs, who are paid an annual fee for all patients registering for provision of contraceptive services (this can include giving advice, but perversely excludes boys!). A form (called FP1001) has to be completed for each person registered. We decided to complete these forms for as many young people as possible and to use them as a way of measuring the impact of the clinic. The forms include the patient's age, and we found out that we could easily obtain data on numbers of forms completed in previous years. We hoped to demonstrate that the number of completed forms for teenagers would increase as a result of the clinic. If this were the case then the clinic might be self- funding. For start up costs we were able to secure a small grant from the Health Authority. The staff ran the clinic during their time off for lunch, and were paid for this time.

2) The medico-legal position.

There were two issues here. Firstly nurse prescribing, and then prescribing for teenagers under 16. At that time nurses were not authorised to prescribe medicines (they are now able to prescribe from a limited list, not yet including the pill). We needed them to be able to provide the oral contraceptive pill and possibly a few other things such as anti-fungals. We wrote to both the Health Authority and the Royal College of Nursing for guidance. The advice was vague, but it seemed that provided a doctor was on the premises a nurse could dispense a prescription completed by the doctor. We decided that we would obtain a supply of contraceptive pills and other medications that could be handed out directly by nurses. They would then be replenished by a prescription signed by the doctor at the end of the clinic. This had the big advantage that teenagers received medicines directly

without having to get them at a pharmacy. They could also be shown the pills as they were being instructed in their correct use.

Some of our doctors were unsure if the "Gillick" ruling allowing doctors to prescribe contraception for "competent" young people under 16 without parental consent applied to the proposed nurse run clinic. Again we were unable to get a clear answer on this. Ultimately the responsibility would be with the prescribing doctor and I and my colleague from the other practice agreed to sign all prescriptions generated by the clinic.

We felt that to protect our nurses and ourselves we should produce detailed protocols for the running of the clinic. These covered the following, and were submitted to the Health Authority for approval:

- Prescribing the oral contraceptive pill.
- Prescribing for the under 16s
- Pregnancy testing
- Testing for HIV
- Seeing young people for counselling (including referral for suspected abuse)
- Provision of condoms

3) Negative reactions from the community

From the outset we benefited from the input of senior figures in the local comprehensive school who were very supportive of the project. We arranged for two parents evenings at the school to discuss our proposals. The attendance at these meetings exceeded our wildest expectations. We were able to discuss the project with a very large cross section of parents. The vast majority were strongly in favour of the clinic. Many expressed difficulties in coping with their teenager's sexuality, and relief that something was being done in this area.

We also arranged and advertised a meeting for patients of the two practices. This was poorly attended but those who came were supportive.

4) The problem of "poaching"

One does not have to be a patient of a practice to register for contraceptive services. It would be possible therefore that we might attract patients from other practices to the clinic and deprive them of income. We were fortunate in that the two practices covered almost all the surrounding area so the numbers would be small. However we wrote to neighbouring practices to advise them of our intention to start the clinic. We did not receive any replies.

The next stage was to advertise the clinic as widely as possible. We were greatly helped in this by a group of enthusiastic teenagers from our focus groups. (indeed, the consultation with local teenagers through the Focus Group Discussions and their subsequent involvement was so crucial that this was considered part of the "intervention" in the subsequent wider research project). With their help we designed attractive posters and also produced hundreds of small 10x10cm brightly coloured sticky labels with the clinic name and times of opening. The teenagers liberally distributed these around the town and the school. Both practices also sent out information about the clinic to all registered teenagers. The school nurse and the deputy head promoted the clinic within the school. We even got a small article in the local paper about the opening of the clinic.

Results

The clinic opened in June 1994. 12 teenagers attended on the first day (which proved to be mostly curiosity!). Attendance figures were recorded for the subsequent 18 months of the clinics operation. See **table 3**

Table 3. Number of attenders, gender, prescriptions for oral contraceptive, pregnancy tests done and condoms issued at S Molton teenage drop-in clinic

Period	Number	Female	Male	OCP	Preg Test	Condoms
23/6/94-20/10/94	37	36	1	2	3	32
11/11/94-23/2/95	39	38	1	10	2	327
2/3/95-31/8/95	112	92	20	10	7	91
7/9/95-4/1/96	39	38	1	13	2	22

Some of the variation in numbers is related to school holidays. The time of the clinic was changed at the beginning of September 1995. This was not very well communicated to clinic users and the drop in the figures for the last quarter is because of that (figures picked up again subsequently and have remained at a level of 8-10 per week on average since then)

Teenagers attending the clinic were invited to provide some information about themselves (this was not compulsory, but if fact most did so) and were then registered with the clinic. Number and ages of registered patients as at April 1996 are shown below;

Age (years)	Number
13	3
14	20
15	31
16	15
17	7
18	7
19	7
20	7
>20	7
not recorded	5
Total	103

Overall we were very encouraged by the success of the drop-in clinic. Our nurses very much enjoyed contact with the teenagers and we had very positive feed back from the young people themselves. We were particularly encouraged by the numbers of young teenagers attending, and by the fact that the great majority of teenagers had not previously attended for sexual health services. We also had some success in attracting boys to the clinic, a group who are notoriously difficult to reach.

From the FP1001 records we estimated that the proportion of teenage girls registered in the practices for contraceptive services rose from 8% to 28% during the intervention period. We also estimated that the additional income generated by this means almost covered the running costs of the clinic (but not the start up costs).

Following the success of the pilot project the question was clearly whether such a model of provision for teenage sexual health needs was generalisable. With the help of a S West Regional research grant, a much wider project within the area of the North and East Devon Health authority was set up. This forms the basis of this thesis.

Study Outline

Contacts with teenagers in the pilot project area had confirmed a preference (suggested in the literature) by young people for their own dedicated services and for a drop-in format. We set up a much wider qualitative study amongst young people using a variety of methods and venues to confirm these findings, and also to explore the attitudes of local teenagers to contraception. In particular we wanted to know what the barriers were for young people in accessing sexual health services locally and whether a "South Molton" style drop-in service could help to overcome them. We also wanted to know what local GPs felt about providing sexual health services to teenagers and so we conducted a study amongst all the GPs in the project area. The data obtained was combined with information about what services were available for teenagers to produce a picture of the situation pertaining in the study area at the time of the project. I have called this the "descriptive study".

The quantitative part of the study used 5 pairs of matched practices in the N and E Devon area. We collected data on all consultations by teenagers for sexual health services both before and for an eighteen month period after the setting up of dedicated drop-in clinics in the 5 case practices (set up in exactly the same way as had been done in the pilot project). The other 5 practices acted as controls. The principal outcome measure was consultations for contraception. This was because of the evidence described above that lack of contraceptive use (especially by younger teenagers) is the main factor behind the high teenage pregnancy rate in the UK. Simply attracting more teenagers into general practice, although probably a good thing in itself would not improve pregnancy rates. The hope was that establishing drop-in services would make primary care a more acceptable and effective provider of contraceptive services to teenagers. The data from the pilot project in S Molton suggested that the institution of a new dedicated drop-in style service for teenagers, set up

according to their local needs and circumstances (determined by prior consultation) could significantly increase the proportion of teenagers obtaining contraceptive services. An increase of 10% seemed to be a reasonable aim, and one that could make a real difference to teenage conception rates if it were reproducible on a wide scale. We therefore chose this as the target for this part of the project.

Chapter Two

Methods

In this chapter I first summarise the chronology of the study, showing when the various activities occurred. This is followed by a description of the methods used to obtain data for the descriptive study. Finally I describe the quantitative study of the drop-in clinics including the sample size calculation and details of the participating practices.

Chronology

1997 Pre-project activity. Baseline survey of General Practice activity. Focus Groups in "Case" practice areas. Data gathering for Descriptive Study

1998 Intervention. Drop-in clinics running from mid 1998

1999 Drop-in clinics all running. Second survey of General Practice activity

2000 End of project. Project reporting and evaluation

Descriptive study data

The intention was to build up a picture of what was going on in the project area regarding the provision of sexual health services for teenagers. We did this by the following methods:

- 18 Focus Groups amongst teenagers in the project area (using a semi-structured design that had proved to be effective in getting teenagers to talk about sexual health matters).
- A questionnaire survey of all general practitioners in North & East Devon to assess their experience of and attitudes toward the provision of sexual health services to teenagers.
- A questionnaire study in years 9 and 11 children attending a large local school.
- A questionnaire study of all teenagers attending the 10 study general practices for any reason over a 1-month period.

This qualitative data was combined with local data on teenage sexual health service provision and usage to form the descriptive study that is the subject of chapter 3.

The Focus Groups.

Whilst these informed practice teams in designing locally appropriate drop-in services, they also provided enormous amounts of information.

Eighteen Focus Group Discussions (FGDs) were run with local teenagers living in and around the areas where the five "case" project practices were located. These were designed

to investigate teenagers' attitudes towards seeking help for various sex-related problems and their impressions of different service providers. The groups were single sex, and included either over or under 16 year olds. They were recruited through school and college nurses and youth workers, and the groups took place either in school, college or at youth centres. All those who took part were offered a high street voucher worth £5 for taking part. The groups lasted between 45 minutes and an hour. Discussions were recorded and analysed. Further information was obtained from a short questionnaire administered after the FGD had taken place (Appendix 1). This was not possible for the Redton under 16 girls' group. The same female moderator conducted all the discussions.

The FGD schedule devised was adapted from the one described in Pearson et al[77] in which teenagers were asked who they would advise a friend to seek help or advice from when faced with a series of scenarios related to sex. The approach used is shown in Appendix 2. Responses to these questions were then used to elicit further impressions of different service providers. As a warm up exercise, the teenagers were first asked about the sex education they had received at school. This was considered to be a useful way of opening the discussion on a related but non-threatening topic in order to get the groups used to talking about sex. In reality, this sometimes provoked extensive discussion.

Survey of GP's attitudes

All 321 GPs at the 78 General Practices in North and East Devon were sent a self administered questionnaire and a stamped addressed envelope in the first two weeks of January 1999. A total of 235 GPs from 67 practices returned questionnaires giving a response rate of 73.2%. The survey concerned GPs' attitudes towards, and experience of, treating under 16s for sexual health matters, and their attitude towards the Gillick ruling. The questionnaire used is shown in Appendix 3

Surveys of School Children

Surveys were undertaken to explore knowledge and attitudes of teenagers in one of the study areas. The questionnaire looked at knowledge of local services and attitudes towards them, knowledge about sex and contraception and levels of sexual activity. This provided complementary quantitative data to that obtained through the Focus Group discussions.

A self administered questionnaire was given to all Year 11 (15-16 years, n=119) pupils in a rural Devon school in May 1999. All Year 9 (n=152) pupils received the questionnaire in July 1999. All those in Year 9 (13-14 years, n=161) in June 2000 also took part in the survey. The questionnaire used is shown in Appendix 4 (this also shows the instructions given to the person administering the questionnaire and sample answers). All those present on the day completed the questionnaire and there were no refusals. All pupils were told that they did not have to answer any question they did not want to answer and were reassured of confidentiality.

Completed questionnaires were sealed in envelopes and returned to the project office for analysis.

Teenagers' evaluation of GP services

All teenagers, male and female, aged 13-19 attending the ten participating general practices for any reason during one month in 1999 were asked to take part in a survey. Receptionists distributed questionnaires as teenagers arrived for a consultation. A SAE was provided so that teenagers could seal and send their own questionnaire without fear of it being seen at the practice. They were assured of anonymity and confidentiality. Unfortunately, the numbers responding to this questionnaire were low, with 150 being returned, half each from case and control practices.

In order to try and increase the response rate, GPs and nurses in the practices were asked to give questionnaires to teenagers during their consultations over a further 2-week period. A further 103 questionnaires, 52 from cases and 51 from controls, were obtained. The response rate from all teenagers attending during this period was 19.0%. It was not possible to calculate a response rate for the first phase. The age distribution was similar for both surveys so they were combined for analysis. A total of 197 girls responded and just 55 boys.

The questionnaire asked teenagers to evaluate the service that they received at their GP, details of their use of sexual health services, preferred sources of help for sexual health, and details of sexual behaviour and contraceptive use. The questionnaire used is shown in Appendix 5.

Quantitative Project design: the drop-in clinic study.

The hypothesis to be tested was that within the intervention period the establishment of nurse-led drop-in clinics in case practices would increase the proportion of teenage girls attending for contraceptive services by 10% compared to control practices. The intervention was implemented at the level of a general practice, so a cluster randomisation technique was used to calculate sample size.

The successful drop-in clinic in the pilot project had been set up with very strong community involvement, and in particular involvement of local teenagers. The intervention was designed as far as possible to replicate this model, including the use of Focus Groups to seek the views of local teenagers. The practicalities of exactly how the clinics ran were left to practices to determine, depending on local conditions and feed back from young people.

The intervention period was originally intended to be 12 months. This was extended to 18 months due to slow recruitment by the drop-in clinics. In retrospect this could have been expected from the pilot project data, and the experience of others that it takes time to establish new services for teenagers[78].

Ideally all 78 general practices in the North and East Devon Health Authority (NEDHA) area would have been available for the study. Despite prolonged contact, only 24 expressed interest (this however was a remarkably good response for a project involving considerable extra work for a participating practice). All were sent a short questionnaire to obtain information on the practices, including sexual health and contraceptive provision. Practices with very small list sizes were excluded, and then to avoid bias from confounding variables practices were stratified according to:

- Size
- Rurality
- Availability of youth and other health services (one practice was excluded because it was next door to the Exeter Family Planning Clinic drop-in service for teenagers, and it was felt that this would probably bias results)

- Current services offered

Pairs of practices were then identified and matched as closely as possible for all the above variables. Once the pairs were finalised they were randomised by tossing a coin. The sample size calculation (see below) suggested that a total of ten practices would provide sufficient numbers so five pairs were selected to take part in the study.

Practices had to agree to participate in the trial prior to being allocated to the case or control group.

To preserve the anonymity of the practices involved, towns were given a code name (such as Greenham, Redton, Blueham etc.) and participating practices are referred to as a case or control number only.

Each of the five practices in which the drop-in service was to be offered (cases) was paired with a similar practice not providing this service (controls). This design compensates for increases or decreases in sexual health consultations generally such as might be seen in, for example, the event of a new pill scare. The sample size calculations took account of clustering and used an outcome measure of increase in use of General Practice for contraceptive services by teenagers. The drop-in services would be deemed to be successful if they demonstrated a 10% increase in use during the intervention period compared to control practices.

Data Collection for drop-in study

The outcome measure of a 10% increase in consultations by teenagers for contraceptive services was a pragmatic one. It is unfortunately very difficult to use teenage pregnancy and termination rates (which might be considered the most direct outcome measure) to assess the impact of services, especially at a local level (see for example Wilson et al, who discusses the problems of evaluating a service in Nottingham using this outcome[79]). There are many variables, such as population mobility that make interpretation difficult, and numbers are generally small. For example the highest number of terminations in the NEDHA area (found at Polsloe, Exeter) was 12, of which 9 were to 18 and 19 year olds. Many wards might expect a single teenage birth or termination in a year.

For this project it was originally hoped that changes in the FP1001 contraceptive claim data could be used to measure the success of the clinics. Whilst this data was collected and analysed, for a number of reasons this method was found to be unreliable. Appendix 6

details the problems found. Instead a baseline survey was done using a form for each teenage girl who had attended the practice in 1997 for any sort of sexual health consultation. The form used is shown in Appendix 7. A dedicated person in each practice (either a nurse or a computer specialist) completed these forms using a combination of sources to retrieve the information. All but one of the practices was computerised which greatly facilitated this exercise. Records of contraceptive claims, smear tests, swabs taken and medication prescribed were all used to cross check lists generated of all teenagers consulting during the year 1997 for sexual health matters.

During the intervention period, with the drop-in clinics running in case practices, we used a questionnaire to record all teenage sexual health related consultations in routine surgeries (completed by the GPs at the time of consultation) in both case and control practices. Another questionnaire was produced for use in the drop-in clinics in case practices. The questionnaires used are shown in appendices 8 and 9.

Sample size calculation

The sample size was based on a cluster randomisation. The population of the North and East Devon Health Authority is 474,000 and is served by 300 GPs. The average list size is 1580 per GP. The female population 13-19 in the area at the time of the calculation was 20,000 or 67 per GP.

Data from contraceptive fee (FP 1001) claims at the NEDHA indicated that approximately 15% of 13 -19 year old females were registered for contraceptive services (range 5-25%). For the sample size calculation this figure was used as a proxy for the percentage of teenagers obtaining contraception from their surgery. The aim was to see if the intervention could increase this number by 10% (i.e. to 25%)

A two group chi-squared test with a 0.05 two sided significance level (alpha) will have an 80% power to detect the difference between a group 1 proportion of 0.15 and a group 2 proportion of 0.25 (Odds ratio 1.889) when the sample size n in each group is 247. With a total of 10 practices (5 intervention and 5 Control) this would require approx. 49 patients per practice.

However as the unit of randomisation in this study was the practice rather than an individual patient, it was necessary to apply an inflation factor to the sample size to account for the loss of power to detect a real intervention effect.[80] [81]This involved the development of a variance expression for the difference between the two proportions, which took into account between-cluster variation. Thus the same statistical power could be obtained using cluster randomisation of practices as would have been obtained using individual randomisation.

The effect of clustering requires the application of an inflation factor = $1 + (\langle n \rangle - 1)\rho$ where ρ is the intracluster correlation coefficient (this usually takes values between 0.01 and 0.05) and $\langle n \rangle$ is the average cluster size i.e. the number of patients per practice derived from the above sample size calculation.
Studies randomised by hospital tend have large ρ-values (over 0.25), indicating a high degree of consistency in practice between the hospitals, whilst primary care studies tend to have much lower values - between 0.05 and 0.25.[82]
Looking at the effect of altering the intracluster correlation coefficient, ρ: -

Assuming a ρ of 0.01, the inflation factor would be 1.4, requiring a total of 692 patients and 69 per practice.
Assuming a ρ of 0.05, the inflation factor would be 3.01, requiring a total of 1486 patients and 149 per practice.
Assuming a ρ of 0.025, the inflation factor would be 2, requiring a total of 990 patients and 99 per practice.
The practices that were finally chosen were fairly large (table 6):

Table 4: Size of Practices Selected to Participate in Drop-In Trial

	Practice	No. WTE partners	No. female WTEs	List Size	Women 13-19	Men 13-19
Pair 1	Case 1	7	1	12,948	481	537
	Control 1	7	2.5	14,700	623	689
Pair 2	Case 2	8	2	14,011	541	498
	Control 2	7	1	12,400	511	505
Pair 3	Case 3	4	0.3	6700	230	244
	Control 3	3.5	0.75	5250	198	244
Pair 4	Case 4	5	1	8461	336	348
	Control 4	5	2	7572	315	316
Pair 5	Case 5	5	1	8650	344	370
	Control 5	4.75	1.25	7535	320	349
	Total			98,227	3899	4100

WTE = Whole Time Equivalent

These practices gave access to almost 4000 teenage girls, which is more than enough to detect the change that we were looking for even allowing for the largest ρ value of 0.05.

In fact the recruitment process proved to be lengthier than had been anticipated. Practices took a long time to reply to the initial request since many took some time to bring the matter to a practice meeting in which participation could be discussed by the partners. In some cases, practices or individuals changed their minds about participation after initial involvement. It was necessary for the practices to commit themselves to taking part in the trial before they knew whether they would be offering a drop-in or acting as a control. Some practices were unwilling to do this. Practices also needed to have an interested Family Planning trained practice nurse who could take on the running of the clinic. The practices needed to have a practice list of around 5-6,000 or to be able to combine with another local practice to achieve a list of this size. This was to ensure that a sufficient number of teenagers were present in the practice to justify the drop-in if only registered teenagers used the service. Finally, the design required sufficient similarity between each

pair of practices in order for them to be matched. Eventually, in late spring 1998, the practices were finalised.

The aim of the drop-in clinic project was to replicate as far as possible the methods used in the successful South Molton pilot project to see if such an intervention was generalisable. This intervention had comprised not just the opening of drop-in clinics, but a previous dialogue between health care staff and local teenagers. Everyone involved felt sure that the active involvement of the teenagers themselves had made the clinics work. The intervention that the project was evaluating therefore comprised first the contact with teenagers and then the setting up of the clinics. The following activities were carried out in the case practice areas.

Talking to Young People

Prior to the drop-in clinics launch, young people in each area where there were to be drop-in clinics established were contacted by a member of the research team. These contacts were made through youth workers and schools. Initial small group discussions were held in informal settings and used various participatory tools. Staff from project practices were encouraged to attend and participate. The groups ranged from 4 to 7 young people, aged 13-17. These meetings preceded the more structured Focus Group Discussions that are described below. As has already been discussed, the FGDs were seen as part of the intervention, but they also provided rich qualitative material for the Descriptive Project (reported in Chapter 3) Information was sought from the teenagers about:

- What local sexual health services they knew of
- What local services they used locally
- Local activities for young people
- Where people "hang out"
- What they would like from a service
- Wording of publicity materials for the clinics
- Suitable locations for advertising materials

The purpose of meeting the young people was two-fold. Firstly it was an opportunity to gain information about the local environment for teenagers as well as how the drop-in

would be received and what they wanted from it. Secondly, it was hoped that involving young people from the start would both give them a sense of ownership and begin the process of word of mouth advertising. In addition, in some centres, teenagers became actively involved (as they had in the pilot project) and helped to put up posters and stickers advertising the new drop-in sessions.

Cards with various words on them (such as clinic, private, confidential etc.) were given to each of the groups as a way of examining the most appropriate language for use on the posters. They wanted to see a telephone number where the clinic was, together with information about what the service provided and who was allowed to go. In addition, they were happy with the form of words suggested by the Brook clinics as most appropriate to young people's need. The clinics were therefore advertised with the tag "Free, friendly, confidential sex advice for teenagers." The groups were not happy about it being known as a "drop-in" and so the clinics were known as "Teenage Advice Clinics". Most liked the word "clinic" as it was felt to indicate that the service was official and professional. An example of the resulting poster design is shown in Appendix 10.

The teenagers also made a number of suggestions of local venues for advertising. These included bus stops, telephone boxes, in public toilets, local shop windows, in schools (including school toilets), at sports centres and clubs and in chemists and other doctor's surgeries. They also suggested local pubs and clubs that were known to have a young (sometimes-underage) clientele. In practice not all of these venues proved suitable. For example, it is difficult to advertise generally in schools, although poster displays in school nurse rooms or counsellor's rooms have been feasible in all drop-in areas.

Nurse's Training Day

A training afternoon was held for all the nurses who were to be involved in running the clinics. Speakers were one of the nurses from Exeter Family Planning Clinic responsible for nurse-prescribing from protocols, a practice nurse from South Molton who discussed the South Molton drop-in experience, and the Exeter Family Planning Services co-ordinator who discussed the particular needs of young people. The training day also

provided a discussion forum for the nurses where they shared information and explored the issues around providing services to young people in their area.

Each of the nurses was provided with an information pack about the running of the clinic. This included protocols for dealing with under 16s, confidentiality, client and parent access to records, and child protection, as well as a description of what the clinic would provide and the nurse job description for the clinics. This is shown in Appendix 11. It was emphasised however that these were examples and that practices should develop their own locally appropriate versions.

Supplies to the Drop-in Clinics

In order to help meet the needs of young people, each of the drop-in clinics received a "starter pack" of supplies. It was felt important that young people were able to take their supplies away with them from the clinic, rather than having to go to a chemist to redeem a prescription. Instead, contraceptives were supplied direct to the client and staff then replaced the issued clinic stock using the prescription note.

Each clinic initially received:

- 40 cycles of Microgynon (OCP)
- 24 cycles of Cilest (OCP)
- 20 PC4 (Emergency Contraception)
- 30 On the spot Pregnancy testing kits (Checkmate)
- 12 gross of condoms

In addition, a number of contraceptive information leaflets designed specifically with young people in mind, and with input from young people, were supplied. All are in full colour, and with the exception of the Pill leaflets, use cartoons and graphics, while *Private and Confidential* uses photos of young people:

- 2 x *Here to listen not to tell* - posters advertising confidentiality, including to under 16s
- 40 x *Is everybody doing it?* (FPA, 16pp) -Booklet aimed at 13-17 year olds with information about contraception, and STIs.

- 20 x *4Boys* (FPA, 16 pp) - Booklet aimed at young men aged 13-16, giving information about body changes, sexual development, STIs and condom use.
- 20 x *4Girls* (FPA, 16pp) - Booklet aimed at Young women aged 13-16, giving information about body changes, periods, sexual development, STIs contraception
- 20 x *All you ever needed to know about EC* (Brook, Folded A4 sheet) Leaflet giving facts and dispelling myths about EC use, which also outlines what EC is and what it does, and when to use it.
- 20 x *Cool Lover's Guide to Condom Use* (Brook, Folded A4 sheet) Aimed at young people, particularly men, and emphasising the need to practice using condoms before using them for sex. Also raises using the "Double Dutch" method.
- 20 x *Help! I forgot my pill* (Brook, Folded A4 sheet) Showing how the combined oral contraceptive pill works, what makes it ineffective (eg vomiting, some antibiotics) and what to do in the case of missed or ineffective pill(s).
- 20 x *The Pill, Healthy or Harmful?* (Brook, A4 Folded sheet) Outlines the risks and benefits of taking the COC, with risks shown in an easy to understand format.

20 x *Private and Confidential* (Brook, BMA, GMSC, RCGP, FPA, 14pp) Booklet reassuring young people that they can talk to health care professionals in confidence about contraception, problems and sexual health.

Participating Practices and their Locations

Information for this section has been drawn from visits by the project team to the towns and practices, and informal interviews with practice staff, school nurses, youth workers and local teenagers. For all locations, code names have been used to preserve the anonymity of participating practices.

Pair 1: Blueham

Blueham is a large conurbation in North Devon. Teenagers aged 13-19 comprise 8.89% of the population (n=1847) (Census data 1991). The Family Planning Clinic is based at the Health Centre (not a study practice) and is open weekly. The local college runs a weekly Tuesday lunchtime service for one hour operated by the Family Planning service. However, central Blueham has one of the highest teenage pregnancy rates in the area.

Case Practice 1

The case practice is situated close to the town centre. It is a modern building with several separate entrances. It is about 15 minutes walk from one of the large secondary schools in Blueham, and has good relations with this school and the nurse there. The supply of condoms and on the spot pregnancy tests is restricted, and may also vary by partner. This practice had already tried to run a drop-in service but had had little success and staff wanted to re-focus their efforts.

Control Practice 1

Control 1 is also a very modern building. It is situated a little way out from the town centre in a residential area and just a quarter of a mile from one of the secondary schools. They have referrals from the school counsellor rather than the nurse, who can sign young people out of the school at lunchtime if they need to seek medical advice.

Pair 2: Greenham and Pinkham

Case Practice 2

Greenham is a rural market town and teenagers aged 13-19 comprise 8.4% of its 7417 population (n=623) (Census data 1991

Initiated by the school nurse, an attempt had been made to run a bi-weekly, Monday lunchtime, Family Planning drop-in at the local hospital. Although situated close to the school, this was not successful in attracting clients. At the time of the study any under 16s presenting for Emergency Contraception at the local A&E had their details sent to the school nurse who tried to follow up with advice and supplies. The nearest Family Planning clinic is 14 miles away in Redton.

The case practice is the only one in the town. It is in a modern building in the centre of Greenham, a short walk from the school and has recently modernised and extended its premises.

Control Practice 2

Pinkham has a bi-monthly Family Planning Clinic based in the Health Centre that houses the control practice. A rural market town situated in Mid-Devon, 8.94% of its population are aged 13-19 (n=556) (Census 1991).

The local school nurse holds a Monday lunchtime drop-in at which girls who need Emergency Contraception can call in and she will make them an appointment with one of two identified partners at the control practice, both male. She is also able to do pregnancy tests in school and on very rare occasions when there is no other way to provide EC, she will provide EC under protocol from Exeter Family Planning Clinic. However, she often signs girls out at lunchtime to see the doctor, but both town chemists are closed for lunch. No solution to this was offered

Control 2 is the only practice in the study to rely wholly on hand held notes, with few computerised records, and those on an out-dated computer system. It is situated close to the town centre in a modern building.

Pair 3: Brownton and Mauveham

Case Practice 3

Brownton is a small village in East Devon with 139 teenagers aged 13-19 years out of a population of 1635 (8.50%) (Census data 1991). Its secondary school aged pupils largely attend a school in a small local town, to which they are bussed some 5 miles away. The school has no sixth form. The nearest Family Planning Clinic is in a town about 12 miles away

The practice is in a new building near to the centre of the village It has two further branches, one of which is in Somerset.

Control Practice 3

Situated in North Devon, Mauveham has a teenage population of 385 (8.57%) aged 13-19 years (Census 1991). The secondary school attracts pupils from outlying areas. There is no sixth form and most go to North Devon College for post-16 education. The town has a Family Planning service that is open bi-monthly.

The practice is in a modern building, close to the town centre.

Pair 4: Redton

Redton is a city of some 98125 population and teenagers aged 13-19 make up 8.14% of this of this, numbering 7989 (Census data 1991). None of the city's state schools has a sixth form. There is a Sixth Form College which attracts youngsters from within and without the town and a University - both of these swell its young person population. In addition, workers and students travel in from outlying areas. It has the only daily Family Planning Clinic in North and East Devon, and this is open all day Monday - Friday and Saturday mornings.

Both the control and the case practices are situated in premises which they share with another, separate practice. Both are located in modern buildings with a shared waiting area, and several treatment rooms. The practices are the only ones in the study to claim deprivation allowance for any of their patients, the case claiming for 2.5% and the control for 11.4% of its patients.

Case Practice 4

Situated in a modern building this busy practice is about a mile from the town centre in a residential area that also contains a high student population.

Control Practice 4

This practice is further from the town centre but situated in a suburban area which has its own amenities.

Pair 5: Greyville and Whiteton

Case Practice 5

Greyville is a North Devon seaside town with 13-19 year olds comprising 8.42% (n=921) of the population (Census 1991) and a good deal of seasonal fluctuation due to tourism and seasonal work. During term time, the college runs a weekly lunchtime clinic and there is also a weekly session aimed at young people in the Family Planning Clinic. The case practice is situated on the main road into the town, in a modern building that it shares with the other Greyville general practice.

Control Practice 5

Whiteton is by the sea on the North Devon coast. It has a teenage population of 1117 (8.59% of the population) (1991 Census data). A Family Planning session is run weekly, but on different days for alternate weeks. The practice is situated a little away from the town centre

CHAPTER 3

RESULTS :THE DESCRIPTIVE STUDY

One of the project aims was to try to understand how teenagers in the project area felt about services for sexual health, particularly those based in Primary Care; and also how General Practitioners felt about providing such services. In addition we used data from the baseline survey in project practices and also from the North & East Devon Health Authority and the Family Planning service to determine what services were available for teenage sexual health and what use was made of them. By combining this information we hoped to build up a picture of the situation "on the ground" in our locality in the area of teenage sexual health. The hope was that this information would both inform the setting up of the TAC clinics and also provide a knowledge basis for further work aimed at improving contraceptive provision to young people in General Practice. The methods used have been described in chapter 2. In this chapter I will present the results of this study. This was a very time-consuming part of the project, but immensely rewarding. I hope that by the end of this chapter the reader will feel, like us, a greater sense of insight and understanding about where our young people were coming from in their perception of sexual health and use of sexual health services.

What do GP's think about teenagers? The survey of GP attitudes.

This survey has been described in chapter 2. A summary of the study findings from this survey has been published [61] A fuller account of the results is given here.

Sample characteristics

A total of 235 GPs from 67 practices returned questionnaires giving a response rate of 73.2%. Female GPs (87.8%) were more likely to respond than male GPs (66.4%). More than two thirds (71.6%) of the respondents were male (N = 164) and 28.4% were female (N=65). In North and East Devon, 23.0% of GPs are female. Eighty-six percent had at least some further training in Family Planning (such as the FPA certificate). The ages of the respondents ranged from 28 to 65 and are shown below in Table 5

Table 5: Age of respondents

Age	Percentage
26-35	13.9
36-40	26.3
41-45	21.0
46-50	17.0
51+	21.9

Respondents were drawn from all sizes of practices, and are representative of the percentage of N&E Devon GPs working from different size practices. (See Table 6.)

Table 6: Number (and percentage) of GPs working in different sizes of practice in North & East Devon. All GP's and respondents

Practice size	Number (%) in N&E Devon (all GP's)	Number (%) of respondents
<2500	13 (4.0)	8(3.4)
2501-5000	58(18.1)	45 (19.2)
5001-7500	94 (29.3)	63 (26.9)
7501-10000	63 (19.6)	47(20.1)
10001-12500	29 (9.0)	26(11.1)
125001+	64 (19.9)	45(19.2)

Attitudes towards sexually active under 16s and their treatment

GPs were asked to show whether they agreed, were neutral or disagreed with a series of seven statements about under 16s and sexual activity (a 5 point Likert scale was used.) Two separate questions were asked about parental knowledge: "Where I see girls who are under 16 and having a sexual relationship, I would prefer that their parents knew they had sought my advice" and "Where I see girls who are under 16 and having a sexual relationship, I would prefer that their parents knew they had sought contraception from me". A majority of GPs would prefer parents to know they had been consulted. (70.2% for advice and 76.3% for contraception; see table 7)

Table 7: Percentage of GPs who would prefer that parents knew that they had been consulted by an under 16 year old for advice and contraception

	Sought advice	Sought contraception
Strongly agree	9.9	12.9
Agree	60.3	63.4
Neither agree nor disagree	20.7	15.5
Disagree	7.3	6.9
Strongly disagree	1.7	1.3

Asked to state whether they agreed with the statement "I owe the same duty of confidentiality to under 16s as to my other patients who are over 16", almost all GPs agreed that they do (56% strongly agreeing and only 6.5% disagreeing Table 8). Thus, despite their preference for parental involvement, most doctors are supportive of confidential treatment for under 16s.

Table 8: Percentage of GPs agreeing that they owe the same duty of confidentiality to under 16s as to other patients.

	Percentage
Strongly agree	**55.6**
Agree	**35.9**
Neither agree nor disagree	**2.1**
Disagree	**5.6**
Strongly disagree	**0.9**

Missing data (n=l) excluded. Column totals may not = 100 due to rounding

GPs were asked to agree or disagree with the statement: "If I supply contraception to an under 16 year old girl I am aiding a criminal act". This question was asked because whether or not supplying contraceptives to minors constituted aiding a criminal act, or indeed was itself criminal, formed a major part of the Gillick debate. (The question was resolved as one of intent; summarised by Lord Scarman who had stated during the Gillick debate that "Clearly a doctor who gives a girl contraceptive advice or treatment not because in his clinical judgement the treatment is medically indicated for the maintenance or restoration of health but with the intention of facilitating her having sexual intercourse may well be guilty of a criminal offence").

Most GPs responded negatively to this statement with just 10.7% agreeing (Table 9). Three of those who did agree also qualified their agreement by writing comments next to the question:

"As the law stands but not as currently advised by our advisory bodies." (male, 56)

"Theoretically". (male, 54)

"Surely this is a matter of fact". (male, age not given)

Another respondent commented: *"and if I am, I don't care".* (male, 45)

Table 9: Percentage of GPs who agree that supplying an under 16 year old girl with contraception is aiding a criminal act.

	Percentage
Strongly agree	**2.6**
Agree	**8.1**
Neither agree nor disagree	**12.0**
Disagree	**38.5**
Strongly disagree	**38.9**

When asked to agree or disagree with the statement "I would try and persuade an under 16 year old to wait until they were older before having sex", GPs opinions were divided. Slightly more than a third agreed (36.1%), slightly more than a third disagreed (36.4%) whilst just under a third (27.5%) neither agreed nor disagreed with this statement. (Table 10)

Table 10: Percentage of GPs who agree that they would try and persuade an under 16 year old to wait until they were older before having sex.

	Percentage
Strongly agree	5.2
Agree	30.9
Neither agree nor disagree	27.5
Disagree	30.0
Strongly disagree	6.4

Respondents were asked to agree or disagree with the statement "I think that most under 16 year old girls are too immature to be having sex" and again opinions were divided. Only about a quarter agreed with this statement and slightly more than a third of GPs disagreed (Table 11).

Table 11: Percentage of GPs agreeing that they think most under 16 year old girls are too immature to be having sex

	Percentage
Strongly agree	3.0
Agree	23.6
Neither agree nor disagree	34.8
Disagree	31.3
Strongly disagree	7.3

GPs disagreed with the statement "Allowing the under 16s access to contraception only encourages under age sex", with 30% strongly disagreeing. Just 3% agreed with the statement (all of whom were male). (Table 12).

Table 12: Percentage of GPs agreeing that allowing under 16s access to contraception only encourages underage sex

	Percentage
Strongly agree	0.4
Agree	2.6
Neither agree nor disagree	9.9
Disagree	57.8
Strongly disagree	29.3

Respondents were asked how comfortable they were giving sexual health advice to under 16s and supplying them with contraception, again using a 5 point Likert scale. Overall, GPs were much more comfortable giving advice than actually supplying contraception. Very few GPs (3.4%) were uncomfortable giving advice and slightly more (15.6%) supplying contraception. However, nearly twice as many were comfortable giving advice compared to supplying contraception (66.6% vs. 37.2%). No women, and 4.4% of men were uncomfortable giving advice, whilst twice as many men (18.6%) as women (9.4%) were uncomfortable supplying contraception. These differences did not, however, reach statistical significance. (Table 13).

Table 13: How comfortable GPs feel giving sexual health advice and supplying contraception to under 16s

	Giving advice	Supplying contraception
Very comfortable	17.0	5.6
Comfortable	49.6	31.6
OK	30.0	47.2
Uncomfortable	1.7	13.9
Very Uncomfortable	1.7	1.7

GPs were asked to estimate what percentage of young people have sex before they are 16 years old. Estimates for under 16 sexual activity quoted in chapter 1 are from 25% to 49% for females and 23% and 74% for males. The range of answers given for this by GPs was between 3% and 98%. A third of GPs believed that less than a quarter of under 16s have had sex, whilst more than a quarter of GPs thought that over half of teenagers were sexually active before the age of 16 (Table 14).

Table 14: GPs' estimates of the percentage of young people sexually active before the age of 16 (Percents)

Estimated percent of sexually active under 16s	Percentage of GPs
0-15%	13.4
16-25%	20.7
26-35%	22.6
36-45%	12.9
46-55%	18.0
56%+	12.5

Experience of treating under 16s for sexual health

Respondents were asked how many under 16 year old girls they saw each month for sexual health matters, and how many boys. GPs indicated that they see teenage girls between 0 and 10 times a month. Where a range was given as an answer, a midpoint has been used. Male and female GP's gave significantly different answers to this question ($p<0.05$). Around a third of males stated they saw under 16 years old girls less than once a month, compared to 7.8% of females; this has been recorded as 0.5 times a month. Just under a quarter of male GP's and over a quarter of female GP's see teenage girls once a month about sexual health issues. Over a quarter of females (but less than 1 in 5 males) see these girls more than twice a month. A few male and female GP's never see these girls for sexual health (Table 15).

Table 15: How frequently GPs see under 16 year old girls for sexual health

Number of times per month teenage girls seen for sexual health	Men (%)	Women (%)
0	2.5	4.7
0.5	34.4	7.8
1	22.7	26.6
1.5-2	22.7	32.8
2.5+	17.8	28.1

GPs were also asked how frequently they saw under 16 year old boys for sexual health, and 79.8% responded that they never did. A further 17.2% saw boys less than once a month and the remaining 3.0% saw boys between 1 and 6 times a month.
Respondents were asked whether they felt that this was less, about the same, or more frequently than others in their practice, or if they didn't know. Overall, nearly half (46.6%) believed they saw girls about as often as others in their practice. Women were much more likely (36.9%) than men (4.3%) to report that they saw under 16s about sexual health "More frequently" than other partners. Women were also less likely to report "Don't

Know" for this question. Differences by sex are statistically significant ($p<0.05$). (See Table 16)

Table 16: How GPs felt their case load of under 16s compares to other partners

	Percentage	
Frequency of seeing under 16s compared to other	**Men**	**Women**
Less frequently	**27.2**	**10.8**
About the Same	**50.6**	**41.5**
More frequently	**4.3**	**36.9**
Don't know	**17.9**	**10.8**

Asked what sexual health services under 16 year old girls most often came in for, about half of GPs reported they saw girls for contraceptive pills, and nearly a third said they saw girls most often for Emergency Contraception (EC). Eight respondents ticked more than 1 category, usually pills and EC. Of those who ticked the "Other" category, consultations for menstrual problems, acne and general teenage services were given as most frequent (Table 17).

Table 17: Sexual health services most often requested by under 16 year old girls

Under 16 year old girls seen most often for:	Percentage
Emergency Contraception	31.3
Contraceptive pills	48.9
Advice on contraception	12.4
Condoms	0.0
Pregnancy Tests	0.9
2 or more categories ticked	3.0
Other	3.4

GPs were asked to indicate how often under 16s were supplied with written materials when consulting for sexual health matters. A quarter of women, compared to just 3.7% of men stated that they always supplied written information to under 16s consulting about sexual health. Differences between the sexes were significant ($p<0.05$). (Table 18).

Table 18: How frequently GPs supply written information to under 16s consulting about sexual health

How frequently written material supplied	Percentage of men	Percentage of women
Always	3.7	25.0
Usually	31.1	34.4
Sometimes	43.5	28.1
Rarely	18.0	7.8
Never	3.7	4.7

Respondents were asked whether or not they followed written guidelines when treating under 16s, and if they did, an open question asked them to state what guidelines were used. Fewer than one in five GPs (16.1%) stated that they followed written guidelines, with 83.9% stating they did not. Two respondents wrote next to the question:

"*Yes, what guidelines*"? (male, 37)

"*What guidelines*"? (male, 45)

Of those who stated that they did follow guidelines, about half named Gillick as the guidelines followed. Others included guidelines written by the practice, the BMA, Family Planning Clinic, the Local Authority and the General Medical Council.

The "Gillick" ruling

The Gillick ruling on treating under 16s for sexual health was given as follows at the end of the questionnaire: Doctors treating under 16s should:

- Judge whether the patient understands the potential risks and benefits of any treatment given.
- Emphasise the value of parental support and try to persuade the patient to inform, or let them inform, their parents.

- Reassure the patient that if they do not want their parents involved, confidentiality will be respected.
- Make a judgement as to whether or not the young person is likely to start or continue having sex whether or not the doctor provides contraception.
- Assess whether the patient's mental or physical health is likely to suffer if they do not receive contraceptive supplies.
- Consider whether the patient's best interests would require the provision of contraceptive supplies.

Respondents were then asked whether they were uncomfortable with any aspect of these provisions. Less than a fifth (17.4%) stated that they were. A space was provided in which GPs were asked to say why they were uncomfortable, and 25 GPs (10.6%) made comments here.

Several commented that under 16s who were not Gillick competent were also at risk from unprotected sex, and that they were not protected by this ruling:

"Often young people will have sex anyway and getting pregnant can be a disaster. Hence contraception v. important even if not Gillick competent". (male, 38)

The doctor here is not uncomfortable with the Gillick ruling because it is too liberal, but rather because it restricts effective service to some of those most vulnerable. Similarly, the speaker below suggests that many under 16s may not be capable of understanding their treatment, though this is not necessarily a reason not to treat:

> *"Most under 16s do not fully understand the 'risks and benefits' of [prescriptions] or early sexual activity."* (Female, 42)

Others found particular parts of the Gillick judgement unhelpful. Some felt it inappropriate to try and "persuade" young people to inform their parents and preferred less forceful approaches.

> *"Not happy trying to persuade them to inform parents. Always inform them of the law".* (Female, 55)
>
> *"The use of the word persuade in point 2; I would prefer to counsel the patient to decide for themselves the benefits of discussing the situation with their parents".* (Male, 43)

"I think too much emphasis on informing parents can lead teenagers to believe you will break confidentiality. I advise them (invariably girls) to talk to their mum but emphasise that I would not tell them myself". (Female, 38)

The responsibility placed on the doctor to "judge" whether or not the young person was likely to have sex with or without contraception was also disliked by some GPs:
"Nothing to do with the Doctor, I am not Guardian of [patient] morals." (Male, age not supplied)

"It's a bit patronising and condescending - how can you really make such a judgement"?
(personal details not supplied)

These comments suggest that judging their patients is not part of a service that all doctors feel comfortable providing, and that some find it inappropriate to be asked to do so.

Other respondents commented that they *were* happy with the provisions:

"*Seem logical and sensible*" (Male, 52)

"*Allows me to make a professional judgement for each teenage girl presenting*" (Male, 44)
"I think they formulate as balanced approach as possible to the problem that we must face". (Female, 40)

These respondents apparently regard the Gillick judgement as a fair framework for them to use in assessing the needs of under 16s presenting for sexual health needs.
Finally on the questionnaire, space was given where respondents were asked to add any comments they had about treating the under 16s for sexual health matters, and 69 respondents (30.0%) did so.

Several GPs made comments suggesting that under age sexual activity is not really a medical issue, or at least not only a medical issue, but one which requires educational input and a supportive social context.

"Making this a medical issue is mistaken. Contraception is often the "way in" to discussions about sexual health and individual responsibility but is in a way the end of the

road and the only bit of it that is "medical" which is why it would be nice to have concerned parental input on wider issues". (Male, 53)

"Sexual health needs to be made an educational priority as much if not more than a "health" priority. Preferably starting as young as primary school". (Male, 38)

These GPs do not want to be seen as the prime provider responsible for helping teenagers to avoid the dangers of unsafe sexual activity. Teenage sexuality is seen by them in a much wider context; including educational and parental input as well as societal attitudes. Some, like the respondent below, consider the breadth of the problem almost insurmountable:

"Little will change with the British attitudes to all matters sexual"!

(Male, age not supplied)

Some comments showed that GPs are adopting a pragmatic approach, registering some disquiet about under age sexual activity but concerned none the less to minimise risks:

"*Although I feel strongly that under age sex is undesirable on physical and emotional grounds, it is a fact of life and we must be able to give support and advice when required.*" (Female, 40)

"I feel contraception for under 16s is the lesser of the "evils" compared with TOP or being a teenage mum". (Female, 46)

"Having sex and getting pregnant is worse than having sex and not getting pregnant. Therefore offer advice/treatment to all". (Male, 51)

Underage sex is seen as "undesirable" and the "lesser of the evils" - both of which illustrate the negative way in which many adults view teenage sexuality. In this case, the consequences of female sexuality are paramount and the risks are entirely based on the possibility of pregnancy - only one respondent mentioned their disquiet at seeing so few boys. The questionnaire had referred to "sexual health" throughout to try and expand the scope of consideration beyond just contraceptive provision, however, one GP commented :

"*I don't like your use of the phrase 'treated for sexual health' - there is no disease here"!* (Male, 45)

There may be some tension between the GPs awareness that sexual health extends way beyond the medical, and the fact that many seem to view it in a very narrow medical model

(largely concerned with avoiding teenage pregnancy) rather than promoting healthy sexuality.

Some GPs emphasised the distance, both in age and understanding, between their own, and the current generation of young people:

"*Most are much more mature than previously".* (Male, 48)

"*They tell me people over 40 don't have sex so what would I know about it*." (Male, 47)

The latter comment emphasises the feeling of "us" and "them."

A number of different comments were made about the maturity of under 16s seen for sexual health consultations:

"*Most of them are bright, Gillick competent and eager to learn. We all make mistakes*." (Female, 48)

However, more GPs were concerned that the 16 year old cut off point didn't allow for the range of maturity seen among teenagers, because of this, it was felt that while guidelines may be helpful, rules were not:

"*Physical age and maturity vary and 16 years is an arbitrary point, often not useful"* (Female, 55)

"Generally they are very mature and quite self-confident which suggests that many less confident are frightened off" (Male, 45)

"The maturity of under 16s is as varied as older teenagers. Often it is the immature who have most sex and need most help and advice. Sadly many are too scared to seek help from me as they worry (wrongly) that their parents will be informed against their will". (Male, 38)

Both these respondents sense that there is fear involved for young people confronting the medical profession about sexual health. None, however, mentioned embarrassment, which may be a considerable influence in preventing teenagers consulting their GP. These comments also recognise that those under 16s who consult their GP for contraception are

probably the more mature, leaving those who are less mature but still having sex at greater risk, this view summed up by the comment below:

"*I am less concerned about those that come to surgery than those that don't (but are sexually active) and whose first encounter is a TOP request.*" (Female, 38)

Several GPs commented on the way in which they currently deal with requests from the under 16s:

"I would always strongly encourage the < 16 years to try and wait if they are not yet sexually active, but once they have made the decision I would try my utmost to prevent unwanted pregnancy and the sequalae, & advise always condoms to help [reduce] the risk of STDs" (Female, 34)

"*I always add in my counselling that if a young person has any friends who might be at risk my practice will see them with sensitivity and confidentiality.*" (Male, 43)

Several comments were made suggesting ways in which the respondents felt teenagers could be better served than they were currently:

"Schools and youth clubs have an amazing ostrich attitude. Why no condom machines in all DCC schools??? Youth Clubs??? Why cannot adults recognise their (and others) children's sexuality Why can't GPs provide and prescribe condoms????" (Male, 45, punctuation in original)

"*Emergency contraception should be more freely available - ?pharmacy license. A&E Depts! not just GP and FP clinics as at present (usually).*" (Male, 44)

"? School nurse able to supply emergency contraception incl. Condoms" (Male, 51)
"They need an option away from surgery where they can drop-in" (Male, 39)

Most of these are aimed at reaching young people away from the General Practice surgery, taking the services to the young people rather than the reverse. Others suggested ways in which general practice service could be made more appropriate:

"*Would prefer if<16 had got access daily to female nurse led contraception services [with] the nurse having prescribing rights.*" (Male, 40)

Discussion

The survey achieved a good response rate and a representative sample of GPs from different sized practices working in North and East Devon. Women GPs were slightly over represented and this may lead to some bias in the answers, particularly as women are likely to see under 16 year old for sexual health issues more frequently than their male counterparts.

Observations derived from this study are:

- Despite their preference for under 16s' parents to be informed if they seek help for sexual health issues from their GP, this is not something most would do themselves - over 90% recognise that they owe the same duty of confidentiality to under 16s as to other patients. Most seem to be comfortable with providing this service to teenagers. However a few were concerned that their involvement constitutes a criminal act, or simply encourages under age sex. However, more GPs felt uncomfortable supplying contraceptives than giving advice to this group.

- Whilst a third of GPs agreed that they would try and persuade an under 16 to wait before having sex, only a quarter thought that most were too immature to be having sex. As the comments section showed, this may be because GPs are aware of the arbitrary nature of the 16 year old cut off point in terms of teenager maturity, which they see as very varied.

- There seems to be a need for GPs to be better informed about the proportion of under 16s estimated to be sexually active. The range of answers given was wide, with many either over or under estimating the extent of under age sexual activity. A clearer awareness of the extent of sexual activity before the age of 16 could enable them to judge more accurately the size of the need for sexual health services among their patients, and to target their efforts more effectively.

- Although nearly half of GPs said they see under 16 year old girls most frequently for contraceptive pills, a third saw them most frequently for Emergency Contraception. This high level of EC requests may indicate unmet need for regular contraceptive methods. Consultations for EC provide an opportunity to encourage young people onto more effective methods.

- Written material is particularly important for the young in order to clarify information received during a consultation which may be embarrassing and difficult for them; young people are also more likely than older people to demonstrate poor compliance with pills and other contraceptive regimes. It is vital that young people be given written information about what to do in the event of a missed pill, as well as when to use EC and how to obtain it. Only a tenth of GPs always supply written material to under 16s.

- The number of under 16 year old girls sexual health consultations conducted in a month varied from 0 to 10. However, the vast majority of GPs never see under 16 year old boys for sexual health issues. This may contribute to GPs views that their role in promoting healthy sexuality is confined to preventing pregnancies, and to a lesser extent, STDs.

- Many GPs seem aware of the difficulties of reaching sexually active under 16s and their comments reflect their efforts to provide reassuring, confidential and non-judgmental services to this group. However, more needs to be done in terms of encouraging under 16s to use services. GPs may need more useful guidelines about under 16s, providing information about how to attract teenagers and what to include in consultations, rather than just providing regulations about their treatment as the Gillick ruling does.

Knowledge Of Sexual Health Matters, Use Of Health Professionals And Sexual Behaviour Among A Group Of Year 9 And Year 11 School Children: The Surveys of School Children.

This survey was carried out in a single large school within the study area as described in chapter two. As part of the descriptive study we wanted to know how much information local young people had about sexual health services and what they thought of them. A school survey seemed the most practical way to gather this information. A self-administered questionnaire was given to all Year 11 pupils (age 15-16)) in May 1999. All Year 9 pupils (age 13-14) received the questionnaire in July 1999 at the beginning of their sex education day and this was repeated for year 9 only in June 2000. An evaluation of this day was also completed at the end of the day. All pupils were told that they did not have to answer any question they did not want to answer and were reassured of confidentiality and that no-one in the school would see their completed forms. When they finished the questionnaire, pupils sealed it in an envelope that was collected by the research team. Results were considered significant where $p < 0.05$.

RESULTS. THE RESPONDENTS

Twelve Year 11 pupils were absent through sickness and a further two no longer attended the school by the day of the questionnaire. All the remaining 119 pupils completed the questionnaire of which 53 (44.5%) were boys and 66 (55.5%) girls. Most (75.6%) were 16 years old and the rest (24.4%) 15 years old.

Seven year 9 pupils were absent through sickness. One form was not returned. The results for the remaining 313 (152 in 1999 and 161 in 2000) pupils were available for analysis. Of these, 17 (11.3%) were aged 13 and 134 (88.7%) were aged 14. Slightly more (79. 52.3%) were male than female (72, 47.7%).

The complete analysis of the questionnaire responses is included in appendix 4. My aim here is to summarise the findings that contribute to the descriptive study.

Summary of results.

Sexual experience and use of contraception

Questions related to sexual status and activity and regularity of contraceptive use.

- Just under one fifth of year 9 and around half of year 11 respondents (more girls than boys in both age groups) claimed to have had sex. Of these a quarter claimed to have been 14 and nearly a third 13 or under at the time of first intercourse. A small proportion of sexually active girls had first had sex with a partner considerably older than themselves.
- More than a quarter of sexually active respondents sometimes or often had sex without using contraception

Use of GP services

Questions were asked concerning respondents' knowledge about and use of their GP.

- Nearly all knew where their doctors' surgery was
- Most knew the name of their doctor and nearly one third had attended in the previous 5 months
- For around a fifth the surgery was more than 5 miles from home
- For the majority of both year 9 and year 11 respondents, appointments to see the doctor were made by parents and they did not get to the surgery independently.
- Half of year 9 and one third if year 11 respondents had never seen the doctor on their own.

Knowledge of local sexual health services

Questions related to local Family Planning facilities and to the newly established teenage advice clinic (TAC).

- Two thirds of respondents knew that anyone could get contraception and advice at a Family Planning Clinic, but around a third thought that FPCs were for young families and some that they were for married people.
- Three quarters of year 9 and half of year 11 respondents did not know where their nearest Family Planning Clinic was (especially boys) and almost none knew when it was open

- Around half of respondents knew about the TAC clinic locally, but few knew when it was open.
- Nearly half of year 9 and three quarters of year 11 respondents knew where to get free condoms.

Attitudes toward health professionals

Questions concerned feelings about GPs and school nurses (included because the pilot project research suggested that these were potentially key providers of sexual health services to young teenagers).

- Half of respondents felt that their doctor was someone that they could talk to if they were worried about anything and three quarters would trust the doctor to keep information confidential and treat them with respect.
- Over one third felt that getting a quick appointment would be difficult.
- Half of female but less than one fifth of male respondents would rather see a nurse than a doctor about problems. About half of male and two thirds of female (especially younger female) respondents would rather see a same-sex doctor.
- About half of younger, but less than one fifth of older girls would be embarrassed to talk to a school nurse about sexual matters. For boys about half would be embarrassed at both ages.

Knowledge about sexual health matters

Questions aimed to establish respondents level of knowledge about contraception and sexually transmitted infections.

- One third of all respondents did not believe or were not sure that teenagers under 16 were able to get contraception from a doctor or clinic without their parents being told.
- Knowledge about emergency contraception was sketchy and there appeared to be inappropriate concern about recurrent use.
- Nearly all respondents identified HIV as a sexually transmitted infection, but only about one third recognised chlamydia or warts as such.

The following 5 questions concerned use of various local services. Those answering affirmatively were asked subsequent questions. Responses are summarised below.

Questions

Have you ever been to the doctor for contraception or another sexual health matter, including period problems or concerns about body changes?

Have you ever been to a Family Planning Clinic (FPC) for contraception or other sexual health matter including period problems or concerns about body changes.

Have you ever been to the Brownton TAC clinic for contraception or other sexual health matter including period problems or concerns about body changes?

Have you ever been to the School Nurse for contraception or other sexual health matter including period problems or concerns about body changes?

Have you ever spoken to a youth worker about contraception or other sexual health matter including period problems or concerns about body changes?

Comments

- Of the fifteen Year 9 girls who said they were sexually active, nine had not been to see any health care professional about sex or contraception. One girl had only seen the school nurse (for a pregnancy test). Four had seen both the GP and the school nurse. The GP was seen by 2 girls for the pill, one of whom also had EC. One girl had only EC from the GP, and 1 received a Depo injection. One girl had only seen the GP but didn't say why.
- The school nurse had provided one pregnancy test and condoms to the Year 9 girl who got Depo from her GP, and condoms to a girl who got the pill from her GP. The nurse also referred one girl to the GP for EC. One of the girls had a pregnancy test from a youth worker.
- A further six Year 9 girls saw their GP for problems relating to periods, and two for acne. One had seen the school nurse about period problems.
- Of the twelve sexually active boys in Year 9, one had condoms from a youth worker and the rest had not seen anyone about sex or contraception. One boy said he had seen both a school nurse and TAC but did not say why, he had ticked "I'd rather not say" for details of his sexual activity.

- Of the 15 sexually active boys in Year 11, only 1 had consulted a health professional about sexual health - he saw both a Youth Worker and a GP. Of the 35 sexually active girls in Year 11, 21 had seen a health professional for issues of sexual health. All those using the FPC, a school nurse or a Youth Worker had also been to their GP. Two of those using TAC had only been there, and 1 had also seen a GP. Fourteen sexually active girls had not seen any health professional.
- Of the girls going to the GP, 12 went for the pill, 5 for Emergency Contraception, 2 for a pregnancy test, and 1 for treatment for herpes. The boy went because of a swollen groin.
- The one girl going to Exeter FPC had a pregnancy test (PT) and subsequent TOP. She had also had a PT at the GP.
- Of the girls going to TAC all 3 went for the pill and one of those for advice about smoking and the pill. One of these had also seen a GP about the pill.
- Of the girls going to the School Nurse, 1 went for EC (she has also had EC from the GP), 1 for a pregnancy test (she has also been to the GP for the pill) and the third for herpes (she also saw a GP for this).
- The boy went to a Youth Worker for condoms and the girl for general advice, she has also been to the GP for the pill.

RESULTS -FURTHER COMMENTS

A space was provided where respondents were invited to include any additional comments. Half (49.7%) of Year 9s and a third of Year 11s (36.4%) used this space to make comments. In both cases, more girls than boys commented, and this was significant in Year 9 (chi square = 5.638, DF == 1, p = 0.018). The topics that were raised are shown below. More than one topic was raised in some comments, with 74 Year 9s making 111 comments and 43 Year 11s making 55 comments. Comments below are reproduced verbatim.

Condom availability

Ten comments (7 in Year 9, 3 in Year 11) were made asking for condoms to be made more readily available, including in school:

> *"I think that it should be made easier for young people to get free condoms by making them more available."*
>
> (Female, sexually active, no service use, 16)

"I think we should have condom machines in the girls toilets so its less hassle than having to go all the way to the clinic". (Female, virgin, 14)

"Free 'protection' should be more available for under 16s, maby availible from the school nurse".
(Male, virgin, 14)

More services needed

Thirteen comments (8 in Year 9, 5 in Year 11) suggested that there was a need for more services in their area, and a further 11 (6 in Year 9 and 5 in Year 11) that existing services should be more approachable and 'young person friendly'. Several mentioned that the TAC was good, but too remote from them personally. Other problems of rural isolation were evident here.

"The availability of sexual advice or services is inadequate in this region."
(Male, virgin, 15)

"*Information should be closer to home and very confidential.*"
(Female, virgin, 14)

"I think its good that there is the Teenage Advice Clinic as I know a lot of people that go but I think they should open another one in other villages."
(Female, sexually active, no service use, 14)

11 comments (6 in Year 9 and 5 in Year 11) were made suggesting that services should be more youth friendly or particularly aimed at teenagers.

"*Services, clinics and nurses need to be made more available to young people and less 'taboo'.*"
(Female, sexually active, no service use, 16)

"The GP would benefit greatly if they tried to relate to the "youth" rather than seeming to be patronising".
(Male, sexually active, no service use, 16)

"I don't think that in small villages they have enough youth workers or GPs to discuss sex with the children of the village".

(Female, sexually active, no service use, 14)

Issues of service access

Thirteen respondents (7 from Year 9, 6 from Year 11) made comments relating to difficulties of accessing services locally. This included difficulties in getting appointments, and difficulties travelling to services outside the immediate local area:

"It can be hard for people like me to get transport to places like [TAC]".

(Female, virgin, 14)

"It is hard to get to places like FPCs etc. as parents need to drive you."

(Female, sexually active, no service use, 16)

"I know of people who find it hard to get to the doctor to use the morning after pill as they can't get an appointment and always get an answerphone". (Female, virgin, 15)

Embarrassment

Twenty-five comments (16 in year 9 and 9 in Year 11) were made about the embarrassment encountered by students in discussing sexual matters. This inhibited service use of all kinds:

"I think that there are lots of services but I feel slightly embarrassed about talking to them." (Male, virgin, 14)

"If you go to a school nurse then you get embarrassed if anyone found out."

(Female virgin, 14)

"Because sex is a personal thing no one wants to talk to their doctor they've seen for years as he's a family friend and its embarrassing". (Female, virgin, 15)

"Not many people can talk without feeling embarrassed - in fact there is no-one to talk to".(Female, sexually active, no service use, 16)

"In a close knit community like [X] it would be difficult for young people to get free contraception at a clinic without other people finding out which would be embarrassing."(Male, virgin, 16)

These comments show that embarrassment is found at every stage - being seen attending a service, actually talking to someone about sex, and the possibility of it being found out afterwards that they had been to a sex related service.

Lack of knowledge about local services, more youth services

The largest number of comments for both Year 9 (16) and Year 11 (13) concerned the lack of information about where services were and when they were available. Many felt that information should be easier to get hold of, and that services were not advertised well enough.

> "*People always tell us that there are FPCs but never say where*!"
> (Female, virgin, 14)

> *"People know how to have sex and most know about contraception but it's the simple things that you really need to know about like where the nearest FPC is*".
> (Male, virgin, 14)

> *"I think the availability of condoms and advice needs to be publicised more."*
> (Female, virgin, 16)

Lack of information about what services are available is an obvious barrier to their use.

Sex Education

Thirteen comments were made about the need for better sex education, in particular there was a desire for more information about the risks and effects of Sexually Transmitted Diseases. Nine of these were from Year 11 and four from Year 9 (who were just about to do their sex education day when they completed the questionnaire.)

> *"Sex education at the moment is too little too late".*
> (Male, virgin, 14)

> *"I think we should be told more about the STD's we can get through sex. This would encourage people to use contraception*".
> (Female, sexually active, used TAC, 16)

"I think we should do more about ...how sexually transmitted diseases effect your body and what they do to you."

(Female, virgin, 14)

Current services provision sufficient

Thirteen comments were made which indicated that current levels of service provision were sufficient, this was the case for nine comments in Year 9 and four in Year 11. However, in most cases, this was qualified by the fact that teenagers were too embarrassed to use the services or that they were not known about.

"I think there are enough services for teenagers I just don't think people know about them very well".

(Female, virgin, 16)

"I think that these services are good and excessable but you need a lot of confidence to go to one and they should be advertised more, as many people don't know of them."

(Male, virgin, 14)

"I think that there are enough services in [Brownton] that I can go to but am just nervous to go".

(Female, virgin, 14)

Confidentiality

Six respondents mentioned confidentiality as a key issue in service provision, five Year 9s and one Year 11.

"Teachers and school nurses should make people more aware of strict confidentiality."

(Female, virgin, 16)

"People you tell must be trustworthy or else you don't feel confident talking to them."

(Male, virgin, 14)

Openness about sexual issues

Five Year 9 comments wanted more openness and information about sexual matters.

"I think contraception should be freely available and it should not be made so hard for youth and elders to talk about sex". (Male, virgin, 14)

"I think we should have more discussion in class"
(Female, virgin, 14)

DISCUSSION AND COMMENT ON SURVEY RESULTS

Access to the doctor may be restricted for the half of respondents who do not live in the same town as their GP. Reflecting the school's rural intake, one in five were registered with a doctor more than five miles away from their home. Most knew who their doctor was, but a high proportion of older boys stated that they did not know their doctor's name. Younger boys and girls are more likely to rely on their parents to make appointments at the doctors and to attend appointments with them. This may make attending alone for a sexual health matter daunting. Whilst the differences between boys and girls in Year 9 were minimal, by Year 11, girls are more likely to deal with their medical needs alone than the boys. The respondents often noted problems of access for all services. Several commented that they couldn't always get to the places where services are located. If services are local, however, fear and embarrassment about being seen going to a service were mentioned.

On the whole, this group was not well informed about local sexual health services. A third did not know what an FPC does and two thirds didn't know where their nearest one was located. This may be a reflection of the relative infrequency of FPC services locally - with a once a week service nearly 10 miles from the school and the daily service more than 20 miles away. One half had heard of TAC (this service had been specifically advertised in the school), but only a tiny proportion knew when it was open. This was also true for FPC opening times. Lack of knowledge about specific service details may prevent their use. Those who are not aware of the role of an FPC are unlikely to try and find out more details about it. Nearly half did not know any source of free condoms. Girls and the older age group were generally a bit better informed than boys and the younger age group. Lack of advertising about local services was an issue for those making comments.

On the whole, respondents were positive in their attitudes towards health professionals, with most feeling that they could trust their doctor and school nurse to keep confidence and their doctor to treat them with respect. Nearly half thought they could talk to their GP about anything. Fewer thought that quick appointments were easy to get, with a third

thinking it would be difficult. Interestingly, this perception was more likely in those who had actually made an appointment for themselves. Quick appointments are vital for those needing Emergency Contraception. Year 11 girls were more likely than boys to think they could talk to the school nurse about sex without embarrassment, and many girls would rather see a nurse than a doctor, reflecting their preference for speaking to a woman. About half of all respondents would rather see a doctor of their own sex. Whilst this might be expected among the girls, it is interesting that boys would also prefer a same-sex consultation.

Levels of knowledge about sexual health issues were patchy. Few were aware of Sexually Transmitted Diseases other than HIV/AIDS and perhaps because of this, most wrongly believed HIV to be the UK's most common STD. Again, those who commented were aware of this gap in their knowledge and requested more STD information in their sex education. Most knew that they wouldn't necessarily be able to tell if they had an STD, but a third did not. Only half were aware of the correct time limits for Emergency Contraception, although older respondents and girls were better informed. Most were uncertain about the safety of its repeated use or its effectiveness. Two-thirds of respondents knew that confidential treatment was available to under 16s, a third were unsure - including 14.4% who thought this was false. It is interesting that by Year 11 more boys believed that this was true than girls and this may be a barrier to girls' service use.

There is considerable unmet need for sexual health services among this group. In Year 11, half the girls and more than a quarter of the boys claim to be sexually active. In Year 9 a fifth of girls and 16.5% of the boys say that they have had sex. Of these, only half said that they never had sex without using contraception and 13.0% said that they didn't usually use any contraception. A third of sexually active Year 11's and a quarter of sexually active Year 9's claimed to have had four or more sexual partners. Most were not using services, with nearly two thirds saying they had never seen a health professional about sexual health. In Year 11, one girl had had a termination and another had been treated for herpes.

The responses to the question about age of first partner were interesting. No Year 11 boy had first sex with a partner more than 2 years older than himself and no Year 9 boy with a partner more than three years older. For both boys and girls in Year 11, the greatest proportion had first sex with someone of the same age. The same number of Year 9 girls had a first partner of the same age, one year older or two years older. Year nine boys claimed partners of one or two years older. However in both years, some girls had first had sex with a much older partner.

Age differences could not be calculated for those who would rather not give their age at first intercourse or who said they were less than 13 at first intercourse.

The specific problems of service access for rural teenagers need to be considered. Whilst most are positive in their attitudes towards health professionals, problems of independent access to services are acute. There is also considerable embarrassment in using services in small towns, as anonymity is difficult in such communities.

Teenagers Evaluation of GP services

Methods and Participants

The methods used for this survey were described in chapter 2. The survey was carried out in two stages. One hundred and fifty questionnaires were returned in Survey 1 (Sl) over a period of one month, 75 each from case and control practices. The second stage, Survey 2 (S2), was undertaken because of a very low and disappointing response to the first survey. The practices were asked to redouble their efforts and doctors and nurses were asked to hand the questionnaires directly to young people rather than this being done by the receptionist. Each practice was paid £250 for extra costs that might be incurred.

The second survey ran for two weeks: 103 questionnaires were returned 52 from case practices and 51 from controls. The number of returns varied across practices and was not in all practices associated with size of practice. Of the cases 42.5% of the respondents were from one practice (Sl and S2 combined). Of the controls, 57.2% were from two practices. All teenagers visiting participating practices, regardless of the reason for the visits were invited to participate. An SAE was attached to each questionnaire and a "drop" box was positioned in the reception area of each practice.

Teenagers were asked in the covering letter not to put their names on the questionnaire and were assured that all "answers will be anonymous and treated as strictly confidential". It was also explained that if they did not want to answer any question they should "leave it and go on to the next".

Unfortunately there was no record of the number of questionnaires distributed in the first survey so a response rate could not be calculated. In the second survey the overall response rate was 19.0% (23.1% for cases and 16.0% for controls). Rates varied substantially across practices from 6.6% to 37.3%. Despite our best efforts therefore our results may not be representative of the generality of teenagers consulting.

While the response rate was disappointingly low, the respondents are a group of teenagers on whom detailed data has been collected. Although a self-selected sample of young people, these are teenagers who chose to share their views in a confidential survey whose aim was to "know how well the service suits you".

There are many reasons for non-response. Teenagers often come with their parents for a GP visit. Some will have been seen quickly by their GP and not have had sufficient time to fill out the questionnaire in the surgery. Some may have been reluctant to take home a questionnaire that included many questions about sex and contraception.

Ninety-one girls responded from the case practices and 106 from the control practices, a total of 197. In contrast, 36 boys responded from the case practices and 19 from the control practices, a total of 55. The age distributions by sex are similar for Sl and S2, justifying combining these for analysis. However, proportionately more girls aged 16 and under returned questionnaires from the control practices (59.4% in contrast to46.2%). For boys, comparable percentages are 52.6% and 58.3%. For most of the analysis cases and controls are combined, as distributions in attitudes and behaviours seem similar.

Although the response rate is disappointing (and therefore the findings taken alone must be treated with caution, especially for boys), the range of responses (quantitative and qualitative) and the thoroughness with which young people completed the questionnaires offer considerable insight into these teenagers' perceptions of health services.

Demographic Characteristics of Respondents

The age and sex distributions of respondents are shown in Table 19.

Table 19 Respondents Age by Sex

	Sex		Total
	Female	Male	
AGE 16 and under	105 53.3%	31 56.4%	136 54.0%
17 - 19	92 46.7%	24 43.6%	116 46.0%
Total	197 100.0%	55 100.0%	252 100.0%

Consistent with the youth of respondents, most teenagers were still in formal education. (Table 20 overleaf). About 20% of girls and boys were employed either part or full-time. Five percent of girls and ten percent of boys were looking for work. None of the teenagers was married; over 90% of both boys and girls reported that they were "single", others reported "living together". Three percent of girls and none of the boys reported having children.

Table 20 What is your primary activity by Age & Sex

Sex	Primary Activity Are you:	Age		Total
		16 and under	17 - 19	
Female	At school	83 72.8%	4 3.7%	87 39.0%
	At school (sixth form)	4 3.5%	19 17.4%	23 10.3%
	At college	12 10.5%	28 25.7%	40 17.0%
	At University	0	4 3.7%	4 1.8%
	Employed (part-time)	7 6.1%	18 16.5%	25 11.2%
	Employed (full-time)	4 3.5%	20 18.3%	24 10.8%
	Looking for work	3 2.6	9 8.3%	12 5.4%
	Full time mother/h'wife	0	3 2.8%	3 1.3%
	Other	1 0.9%	4 3.7%	5 2.2%
	Total	114 100.0%	109 100.0%	223 100.0%
Male	At school	29 78.4%	3 9.7	32 47.1%
	At school (sixth form)	1 2.7%	7 22.6	8 11.8%
	At college	0	4 12.9%	4 5.9%
	At University	0	0	0
	Employed (part-time)	3 8.1%	4 12.9%	7 10.3%
	Employed (full-time)	0	7 22.6%	7 10.3%
	Looking for work	3 8.1%	3 9.7%	6 8.8%
	Full time mother/h'wife	0	0	0
	Other	1 2.7%	3 9.7%	4 5.9%
	Total	37 100.0%	31 100.0%	68 100.0%

"Today's" Visit to the GP

Most teenagers participating in the survey were visiting their practice because of illness or injury. Five percent were accompanying someone else; 8% were visiting for dermatological problems; just over 10% were visiting for "check-ups", tests, prescriptions and test results. Eight percent were visiting for injections. Only girls (14.1%) reported visiting for sexual health problems and/or contraception.

The majority of younger teenagers came to the practice with a parent (Table 21).

Table 21: Who have you come with by Age & Sex

Sex		Age		Total
		16 and under	17 thru 19	
Female	Alone	24 22.4%	51 53.1%	75 36.9%
	With a friend	8 7.5%	8 8.3%	16 7.9%
	With boyfriend	4 3.7%	5 5.2%	9 4.4%
	With parent	63 58.9%	26 27.1%	89 43.8%
	With someone else	8 7.5%	6 6.3%	14 6.9%
	Total	107 100.0%	96 100.0%	203 100.0%
Male	Alone	6 20.0%	11 42.3%	17 30.4%
	With a friend	- -	2 7.7%	2 3.6%
	With girlfriend	- -	4 15.4%	4 7.1%
	With parent	23 76.7%	8 30.8%	31 55.4%
	With someone else	1 3.3%	1 3.8%	2 3.6%
	Total	30 100.0%	26 100.0%	56 100.0%

Older teenagers were significantly more likely to come on their own (53.1% of girls; 42.3% of boys). Asked who made the appointment, there are again large age differences for girls; this is less so for boys (Table 22).

Table 22: Who made appointment by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Who made appointment	Me	23 22.1%	55 61.8%	78 40.4%
		Mum	67 64.4%	24 27.0%	91 47.2%
		Dad	3 2.9%	2 2.2%	5 2.6%
		Friend	2 1.9%	2 2.2%	4 2.1%
		No appointment	4 3.8%	2 2.2%	6 3.1%
		Other		2 2.2%	2 1.0%
	Total		104 100.0%	89 100.0%	193 100.0%
Male	Who made appointment	Me	6 21.4%	9 37.5%	15 28.8%
		Mum	19 67.9%	10 41.7%	29 55.8%
		Dad	2 7.1%		2 3.8%
		Friend		2 8.3%	2 3.8%
		No appointment		1 4.2%	1 1.9%
		Other		1 4.2%	1 1.9%
	Total		28 100.0%	24 100.0%	52 100.0%

While 64.4% of the younger girls said "Mum" made the appointment, 61.8% of the older girls made their own appointment. Comparable percentages for boys are 67.9% and 37.5%.

46% of both boys and girls had a "lift" to the practice (Table 23).

Table 23 How got to Practice by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	How got to practice	Walked	42 40.0%	33 35.9%	75 38.1%
		Lift	53 50.5%	38 41.3%	91 46.2%
		Drove myself		14 15.2%	14 7.1%
		Bus	9 8.6%	4 4.3%	13 6.6%
		Taxi	1 1.0%	2 2.2%	3 1.5%
		Other		1 1.1%	1 .5%
	Total		105 100.0%	92 100.0%	197 100.0%
Male	How got to practice	Walked	8 26.7%	7 29.2%	15 27.8%
		Cycled		1 4.2%	1 1.9%
		Lift	19 63.3%	6 25.0%	25 46.3%
		Drove myself		6 25.0%	6 11.1%
		Bus	1 3.3%	3 12.5%	4 7.4%
		Taxi	1 3.3%	1 4.2%	2 3.7%
		Other	1 3.3%		1 1.9%
	Total		30 100.0%	24 100.0%	54 100.0%

Over a third of girls and a quarter of boys walked. Fifteen percent of the older girls and a quarter of the older boys drove themselves. Few cycled or took the bus and even fewer took a taxi.

Asked later in the questionnaire how difficult the practice was for them to get to (using a range of semantic differentials with "sad" and "smiley" faces for clarity), only 12.3% of girls and 14.6% of boys said "very" or "fairly difficult"

The Location is: % (n)

☹ Very **Difficult for most people to get to**	Fairly	Neither	Fairly	Very ☺ **Easy for most people to get to**
Girls **1.5** (3)	**3.1** (6)	**14.4** (28)	**44.6** (87)	**36.4** (71)
Boys **1.9** (1)	**5.6** (3)	**16.7** (9)	**48.1** (26)	**27.8** (15)

The Location is: % (n)

☹ Very **Difficult for me to get to**	Fairly	Neither	Fairly	Very ☺ **Easy for me to get to**
Girls **4.1** (8)	**8.2** (16)	**7.1** (14)	**26.5** (52)	**54.1** (106)
Boys **9.1** (5)	**5.5** (3)	**16.4** (9)	**25.5** (14)	**43.6** (24)

However those who said the location was very/fairly difficult were less likely to have come to the practice alone. Of girls indicating that the practice was very/fairly difficult to get to, only 20.8% had come alone, in contrast to 44.8% of girls who said the practice was very easy to get to. Comparable percentages for boys were 25% and 37.5%.

Evaluations of doctors and practices

Teenagers were asked to evaluate a number of aspects of their doctor's practice (again using a series of modified Semantic Differentials made friendlier by the addition of smiley and sad faces).

Reception Staff

Reception staff were rated highly by most teenagers:

The Reception Staff here are: % (n)

☹ Very **Dis-respectful**	Fairly	Neither	Fairly	Very ☺ **Respectful**
Girls **0.5** (1)	**2.1** (4)	**9.3** (18)	**35.6** (69)	**52.6** (102)
Boys **3.8** (2)	**3.8** (2)	**22.6** (12)	**30.2** (16)	**39.6** (21)

The Reception Staff here are: % (n)

☹ Very **Unwelcoming**	Fairly	Neither	Fairly	Very ☺ **Welcoming**
Girls **0.5** (1)	**3.1** (6)	**6.7** (13)	**48.2** (94)	**41.5** (81)
Boys **1.9** (1)	**7.5** (4)	**11.3** (6)	**43.4** (23)	**35.8** (19)

The Reception Staff here are: % (n)

☹ Very **Unhelpful**	Fairly	Neither	Fairly	Very ☺ **Helpful**
Girls **0.5** (1)	**1.5** (3)	**10.8** (21)	**37.1** (72)	**50.0** (97)
Boys **1.9** (1)	**5.7** (3)	**18.9** (10	**32.1** (17)	**41.5** (22)

The Reception Staff here are: % (n)					
☹ Very Unfriendly		Fairly	Neither	Fairly	Very ☺ Friendly
Girls	**0.5** (1)	**1.6** (3)	**7.8** (15)	**47.2** (91)	**43.0** (83)
Boys	**5.7** (3)	**3.8** (2)	**13.2** (7)	**34.0** (18)	**43.4** (23)

About 90% of girls rated them as fairly or very "welcoming", "friendly", "respectful", "helpful". Slightly fewer boys rated them this highly, although the lowest score given by the boys was 69.8% for "respectful". However, asked in a later question if it was difficult to get a "quick appointment" almost half agreed (49.7% of girls and 43.4% of boys). (Table 24)

Table 24 A quick appointment at the doctors is difficult by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Quick appointment difficult	Agree	55 52.4%	43 46.7%	98 49.7%
		Neutral	20 19.0%	27 29.3%	47 23.9%
		Disagree	21 20.0%	21 22.8%	42 21.3%
		Don't know	9 8.6%	1 1.1%	10 5.1%
	Total		105 100.0%	92 100.0%	197 100.0%
Male	Quick appointment difficult	Agree	16 55.2%	7 29.2%	23 43.4%
		Neutral	8 27.6%	4 16.7%	12 22.6%
		Disagree	4 13.8%	9 37.5%	13 24.5%
		Don't know	1 3.4%	4 16.7%	5 9.4%
	Total		29 100.0%	24 100.0%	53 100.0%

As part of each evaluation question, teenagers were asked to comment on "why you feel like this or add any other comments" about staff. Asked to comment on reception staff, 119

teenagers chose to do so. Of these about 17% were positive; only 13% were negative. Selected, representative comments are shown below (reported verbatim):

Reception Staff: Please say why you feel like this or add any comments about the reception staff

"They always help me out when I am here"

"Polite and helpful"

"If you have a very serious problem & you need to see the doctor that day & they are fully booked they will always do there best to get you in"

"Sometimes they have been reluctant to answer my questions and seek out information"

"It depends on the staff - some are v. difficult, appointments difficult to get, diff questions etc"

"They're doing their job which I understand although sometimes they can make you feel 'this big'!"

"Some seem miserable and can't be bothered to be there"

"They make you feel very small and unimportant because of my records being on show to them I feel very uncomfortable"

"They also answer questions or if they can't they ask someone else"

"Generally quite discreet. It is quite good that the don't know you too well because you wouldn't want them to gossip about you."

"Reception staff are pleasant, however they are not always as polite and helpful on the phone when trying to book an appointment"

The Doctor I Usually See...

GPs were rated very highly:

The Doctor I usually see is: % (n)					
☹ Very **Unwelcoming**		Fairly	Neither	Fairly	Very ☺ **Welcoming**
Girls	**0.0** (0)	**1.0** (2)	**4.1** (8)	**26.9** (52)	**67.9** (131)
Boys	**0.0** (0)	**0.0** (19)	**0.0** (0)	**36.5** (19)	**63.5** (33)

The Doctor I usually see is: % (n)					
☹ Very **Unfriendly**		Fairly	Neither	Fairly	Very ☺ **Friendly**
Girls	**0.0** (0)	**1.0** (2)	**5.7** (11)	**23.8** (46)	**69.4** (134)
Boys	**0.0** (0)	**0.0** (0)	**3.8** (2)	**34.6** (18)	**61.5** (32)

The Doctor I usually see is: % (n)					
☹ Very **Dis-respectful**		Fairly	Neither	Fairly	Very ☺ **Respectful**
Girls	**0.0** (0)	**2.1** (4)	**4.7** (9)	**20.8** (40)	**72.4** (139)
Boys	**1.9** (1)	**3.8** (2)	**1.9** (1)	**38.5** (20)	**53.8** (28)

The Doctor I usually see is: % (n)					
☹ Very Unhelpful		Fairly	Neither	Fairly	Very ☺ Helpful
Girls	**1.0** (2)	**2.1** (4)	**4.7** (9)	**24.0** (46)	**68.2** (131)
Boys	**3.8** (2)	**1.9** (1)	**7.7** (4)	**28.8** (15)	**57.7** (30)

The Doctor I usually see is: % (n)					
☹ Very Rushed		Fairly	Neither	Fairly	Very ☺ Takes time to talk to me
Girls	**4.2** (8)	**3.7** (7)	**4.7** (9)	**27.2** (52)	**60.2** (115)
Boys	**2.0** (1)	**7.8** (4)	**7.8** (4)	**25.5** (13)	**56.9** (29)

About 70% of girls rated them "Very" on the following measures - "Welcoming", "Friendly", "Respectful", "Helpful". GPs received slightly lower scores from the girls for 'Takes time to talk to me", although 60.2% gave this a "Very" positive response. Boys gave somewhat lower scores than the girls, especially in being "Respectful". Fewer than 10% of boys or girls gave negative responses for any of these measures (fewer than 5% for most measures). However, there are clearly a small minority of girls and boys who feel that their doctor is too rushed.

Asked to comment on their doctors, almost three-quarters of the 105 responses were positive, 17% were negative. Selected responses are shown below (reported verbatim):

"Please say why you feel like this or add any other comments about the doctor."

"The doctors are helpful and respectful towards patients."

"I feel that I get on very well with my doctor."

"He is a first class doctor".

"He's alright but rushes you through"

"Isn't very helpful about any of my conditions. Has been extremely rude in the past."

"I always try to see the same doctor therefore I've built up an understanding/relationship - I've been at the same surgery for over 10 years."

"My doctor always talks things over with me" "He's lovelly too"

"My doctor has known me since I was a bump! He always asks how I am and is always good at taking time to both talk to me and listen."

"She's more of an extremely helpful friend than a doctor.

"I get on with my doctor, I like him but lately I have seen a female doctor, I find her easier to talk to about woman's probs."

"My doctor is brilliant. I've had him nearly all my life"

"They are not rushed and they take an interest (not nosey!) in you"

"I'm in there no longer than 2 minutes!"

"I feel very comfortable with my doctor and I trust him 100%. A nice man all around."

"My doctor is very funny but you seem to have to prescribe you medicines and it is hard from him to examine me for I have been his patient since I was a baby"

"I changed the doctor i used to see my doctor is very nice and makes me feel relaxed. She has helped me though a lot and I feel I can talk to her."

"Will talk about other problems or questions I have."

"I am an anxious and nervous person, but always feel i can talk to my doctor about anything which is bothering me."

Information Given by the Doctor

Teenagers were asked if information given by the doctor was "Unhelpful/Helpful" and if it was "Difficult to Understand/Easy to Understand". For both measures the percentages of "Very" positive responses was lower than those for personal characteristics of the GP:

The Information given by the Doctor is: % (n)

☹ Very **Unhelpful**	Fairly	Neither	Fairly	Very ☺ **Helpful**
Girls **1.0** (2)	**2.1** (4)	**4.1** (8)	**37.6** (73)	**55.2** (107)
Boys **5.5** (3)	**7.3** (4)	**3.6** (2)	**41.8** (23)	**41.8** (23)

The Information given by the Doctor is: % (n)

☹ Very **Difficult to understand**	Fairly	Neither	Fairly	Very ☺ **Easy to understand**
Girls **0.5** (1)	**1.0** (2)	**5.2** (10)	**43.8** (85)	**49.5**(96)
Boys **1.8** (1)	**9.1** (5)	**9.1** (5)	**40.0** (22)	**40.0** (22)

Since most respondents chose between only two of the options for most of the measures in this evaluation series, the differences in percentages of the "Very" as compared to the "Fairly" categories suggest that teenagers did perceive differences in meaning. Only 55.2% of girls and 41.8% of boys rated the information given by their doctor as "Very" helpful and only 49.5% of girls and 40.0% of boys rated the information as "Very" easy to understand. For many health problems, including sexual health problems, the GP is an important source of information. These data suggest that there may be room for improvement in giving information to young people.

Of the 87 comments on information given by the doctor, about 60% were positive but nearly 14% were negative including lack of clarity, too rushed delivery and information that was difficult to understand. See below for selected comments (reported verbatim):

Information given by Doctor: "Please say why you feel like this or add any other comments."

"If you don't understand the answer the first time he will always explan again."

"He doesn't tell me enough about what I need to know. Finds questions irritating."

"She explains thing easy + clearly"

"Sometimes appointments are rushed so you can't talk problems through propperly"

"They use complicated names for medication"

"My doctor explains things very clearly and I'm not afraid to ask questions."

"I'm not very good at read thing's sometimes"

"Always explains the use and purpose of medication"

The Nurse I usually see .....

The questions related to the practice nurse were asked only in Survey 2. There was more missing data for this series of questions than for others. Of the 103 respondents to Survey 2 only about four in five answered this series. Sixteen of 78 girls were non-respondents, as were 9 of 25 boys to at least some of the questions. The comments to these questions suggest that this higher level of non-response may be due to young people not "usually" seeing the same practice nurse or not seeing nurses much at all.

Nurses received high positive scores for "Welcoming", "Friendly", "Respectful", "Helpful".

The Nurse I usually see is: % (n)

☹ Very **Unfriendly**	Fairly	Neither	Fairly	Very ☺ **Friendly**
Girls **1.6** (1)	**1.6** (1)	**1.6** (1)	**25.4** (16)	**69.8** (44)
Boys **0.0** (0)	**10.0** (2)	**0.0** (0)	**35.0** (7)	**55.0** (11)

The Nurse I usually see is: % (n)

☹ Very **Dis-respectful**	Fairly	Neither	Fairly	Very ☺ **Respectful**
Girls **1.6** (1)	**1.6** (1)	**0.0** (0)	**35.5** (22)	**61.3** (38)
Boys **5.0** (1)	**5.0** (1)	**5.0** (1)	**35.0** (7)	**50.0** (10)

The Nurse I usually see is: % (n)

☹ Very **Unhelpful**	Fairly	Neither	Fairly	Very ☺ **Helpful**
Girls **1.6** (1)	**3.2** (2)	**1.6** (1)	**24.2** (15)	**69.4** (43)
Boys **0.0** (0)	**15.0** (3)	**5.0** (1)	**25.0** (5)	**55.0** (11)

The Nurse I usually see is: % (n)

☹ Very **Rushed**	Fairly	Neither	Fairly	Very ☺ **Takes time to talk to me**
Girls **0.0** (0)	**0.0** (0)	**9.7** (6)	**33.9** (21)	**56.5** (35)
Boys **15.0** (3)	**5.0** (1)	**15.0** (3)	**15.0** (3)	**50.0** (10)

Scores were higher for girls than for boys, although the numbers for both are relatively small. However, only about half of both boys and girls reported that the nurse was "Very" likely to "take time to talk to me". As more areas of sexual health become nurse-led, this is an aspect of service provision that may need consideration. Nurses also tend to have small and cramped office spaces, which can make confidential discussion difficult.

The majority of teenagers found the information given by the nurse "Very" helpful and "Very" easy to understand (56.8% and 54.3% respectively).

The Information given by the Nurse is: % (n)

☹ Very **Unhelpful**	Fairly	Neither	Fairly	Very ☺ **Helpful**
Girls **0.0** (0)	**0.0** (0)	**6.5** (0)	**33.9** (21)	**59.7** (37)
Boys **5.3** (1)	**5.3** (1)	**5.3** (1)	**36.8** (7)	**47.4** (9)

The Information given by the Nurse is: % (n)

☹ Very **Difficult to understand**	Fairly	Neither	Fairly	Very ☺ **Easy to understand**
Girls **0.0** (0)	**0.0** (0)	**7.9** (5)	**36.5** (23)	**55.6** (35)
Boys **11.1** (2)	**0.0** (0)	**22.2** (4)	**16.7** (3)	**50.0** (9)

Selected comments on nurses are shown below (reproduced verbatim). Only 26 respondents commented on their nurses; only 27 commented on information given by nurses.

Nurse: Please say why you feel like this or add any other comments about the nurse.

"One nurse was very nasty to me and made me cry"

"It all depends on the age of the nurse".

"She always answers any questions I have and takes time to sort out any queries I may have".

"I prefer to see the nurse, for no reason really except it seems less formal than going into the doctors office."

"The nurse I see is very nice she's friendly and takes time to explain to me."

Waiting Area

Teenagers were asked if the Waiting area was "Unpleasant/Pleasant" and if it was "Too Public/Private":

The Waiting Area is: % (n)

☹ Very **Unpleasant**	Fairly	Neither	Fairly	Very ☺ **Pleasant**
Girls **0.0** (0)	**3.6** (7)	**15.4** (30)	**44.1** (86)	**36.9** (72)
Boys **3.7** (2)	**9.3** (5)	**25.9** (14)	**25.9** (14)	**35.2** (19)

The Waiting Area is: % (n)

☹ Very **Too Public**	Fairly	Neither	Fairly	Very ☺ **Private**
Girls **0.5** (1)	**17.2** (33)	**50.5** (97)	**22.9** (44)	**8.9** (17)
Boys **11.1** (6)	**16.7** (9)	**55.6** (30)	**13.0** (7)	**3.7** (2)

The Waiting Area is: % (n)

☹ Very **No Useful Leaflets**	Fairly	Neither	Fairly	Very ☺ **Useful Leaflets**
Girls **2.1** (4)	**3.1** (6)	**21.9** (42)	**35.4** (68)	**37.5** (72)
Boys **5.7** (3)	**3.8** (2)	**15.1** (8)	**49.1** (26)	**26.4** (14)

The Waiting Areas is: % (n)

☹ Very **Nothing for teenagers to read**	Fairly	Neither	Fairly	Very ☺ **Lots for teenagers to read**
Girls **21.9** (42)	**23.4** (45)	**26.0** (50)	**21.4** (41)	**7.3** (14)
Boys **38.2** (21)	**27.3** (15)	**20.0** (11)	**12.7** (7)	**1.8** (1)

Again, most teenagers gave a positive response for "Pleasant"; a greater percentage of girls gave a positive response than boys. However, about one in five girls and a somewhat larger percentage of boys felt that the area was either "Fairly" or "Very" public; which, of course, it is. The issue of "being seen" at the doctors is an important one and is further investigated later in this survey.

Asked about information and reading matter, most teenagers reported that there were "Useful" leaflets. However, a very large minority of teenagers agreed that there is "Nothing for teenagers to read".

This suggests that practices should perhaps make a greater effort to give teenagers reading material that is appropriate for them.

Opening Times

Relatively few teenagers (34.2 % of girls and 24.4% of boys) indicated that opening times were "Very" convenient. However, most gave a positive response to the measures relating to opening times.

The Opening Times are: % (n)

☹ Very **Inconvenient**	Fairly	Neither	Fairly	Very ☺ **Convenient**
Girls **1.6**(3)	**4.7** (9)	**13.0** (25)	**46.6** (90)	**34.2** (66)
Boys **5.6** 3)	**5.6** (3)	**24.1** (13)	**40.7** (22)	**24.1** (13)

The Opening Times are: % (n)

☹ Very **Infrequent**	Fairly	Neither	Fairly	Very ☺ **Frequent**
Girls **0.5** (1)	**1.6** (3)	**10.5** (20)	**45.3** (86)	**42.1** (80)
Boys **5.8** (3)	**1.9** (1)	**23.1** (12)	**36.5** (19)	**32.7** (17)

Overall How Well the Doctor's Surgery Suits Your Needs

Asked the more general question "Overall, how well do you think the doctor's surgery suits you and your needs?" only about 40% said "Very well", half said "Fairly well". Few gave either a neutral or negative response.

Teenagers were asked in a open-ended question, "If you could change some things about this doctors' surgery to make it better for young people, what would you change?" One hundred and twenty four girls and 37 boys gave a comment; some of these cover more than one dimension. (Selected but representative comments are shown below, reproduced verbatim.) Slightly over 40% of girls and half of boys said the practice should be more teenage-friendly. Many wanted more teenage magazines; some wanted leaflets on sex, contraception and pregnancy. A number wanted drinks machines and a number wanted music more appropriate for teenagers. Only a few wanted separate services for teenagers but several wanted a teenage advice clinic. Nearly a fifth of teenagers wanted the environment to be improved: more colourful, more interesting decoration, more "comfy" seats. Only a few commented on staff and some of these comments were perhaps facetious (more "sexy doctors"); however several wanted to see more female doctors or wanted a better gender balance.

Discussion

Teenagers gave positive responses to all the questions in this series. GPs, in particular, were rated very highly. (The low response rate, however, requires that these findings be treated with caution: those most dissatisfied with their practice may have expressed this by not bothering to fill out the questionnaire). As the following results show, teenagers are less positive about the practice and the GP when it come to matters of sex and contraception.

Confidentiality

While most teenagers believe that consultations with their doctors are confidential, 10.3% of girls and 12.7% of boys do not (Table 25).

Table 25 Consultations with Dr are confidential by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Consultations with Dr are confidential	Yes	90	85	175
			87.4%	92.4%	89.7%
		No	13	7	20
			12.6%	7.6%	10.3%
	Total		103	92	195
			100.0%	100.0%	100.0%
Male	Consultations with Dr are confidential	Yes	28	20	48
			90.3%	83.3%	87.3%
		No	3	4	7
			9.7%	16.7%	12.7%
	Total		31	24	55
			100.0%	100.0%	100.0%

A quarter of both boys and girls believe that the Family Planning Clinic would be more confidential (Table 26). A quarter of girls but fewer boys believe that the Teenage Advice Clinic would be more confidential (Table 27).

Table 26 How confidential do you think a FPC would be by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	FPC confidential	Less conf.	11	8	19
			10.8%	8.8%	9.8%
		As conf.	58	66	124
			56.9%	72.5%	64.2%
		More conf.	33	17	50
			32.4%	18.7%	25.9%
	Total		102	91	193
			100.0%	100.0%	100.0%
Male	FPC confidential	Less conf.	4	6	10
			13.3%	25.0%	18.5%
		As conf.	16	15	31
			53.3%	62.5%	57.4%
		More conf.	10	3	13
			33.3%	12.5%	24.1%
	Total		30	24	54
			100.0%	100.0%	100.0%

Table 27 How confidential do you think a TAC would be by Age & Sex

Sex			Age		
			16 and under	17 thru 19	Total
Female	TAC confidential	Less conf.	7	8	15
			16.7%	16.3%	16.5%
		As conf.	21	33	54
			50.0%	67.3%	59.3%
		More conf.	14	8	22
			33.3%	16.3%	24.2%
	Total		42	49	91
			100.0%	100.0%	100.0%
Male	TAC confidential	Less conf.	3	3	6
			14.3%	20.0%	16.7%
		As conf.	13	12	25
			61.9%	80.0%	69.4%
		More conf.	5		5
			23.8%		13.9%
	Total		21	15	36
			100.0%	100.0%	100.0%

Some insights into this concern with confidentiality can be gained by the comments made in relation to sexual health visits discussed in the next section.

Coming to Doctor's Surgery for Contraception or another Sexual Health Matter.

Teenagers were asked if they would be "comfortable coming to the doctors' surgery for contraception or another sexual health matter?" Possible responses were "Yes -I have already been..."; "Yes -I would come..."; and "No". Comments were invited and respondents were asked where they would prefer to go and why.

As Table 28 shows, nearly 60% of girls had already been. About a fifth said they would come in the future. A fifth, however, said they would not be comfortable coming. Considerably fewer boys had already been for a sexual health matter (26.5%). However, a third said they would come in the future. Forty one percent said they would not come.

Table 28 Comfortable seeing Dr about Sexual Health Medicine by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Comfortable seeing Dr about SHM	Yes, already been here	53 54.1%	56 63.6%	109 58.6%
		Yes, will come in future	20 20.4%	21 23.9%	41 22.0%
		No	25 25.5%	11 12.5%	36 19.4%
	Total		98 100.0%	88 100.0%	186 100.0%
Male	Comfortable seeing Dr about SHM	Yes, already been here	6 23.1%	7 30.4%	13 26.5%
		Yes, will come in future	9 34.6%	7 30.4%	16 32.7%
		No	11 42.3%	9 39.1%	20 40.8%
	Total		26 100.0%	23 100.0%	49 100.0%

The comments given offer some explanation for these responses. On the positive side young people felt that their doctor was someone they could trust; someone who knew them (Positive Comments: reproduced verbatim below). A number noted that they felt that their visit would be held in confidence. However, a number of those who would come to their doctor would prefer to visit the Family Planning Clinic, especially if they needed condoms. Reasons why they would not feel comfortable visiting for a sexual health matter varied. (See Negative Comments: reproduced verbatim below). But important among them are confidentiality and anonymity. It is clear that anonymity is very important to some young people. A number of teenagers commented that they knew or their parents knew someone who worked in the surgery and were concerned that their visit might be discussed. In some cases this is expressed as the fact that the waiting area is not "private". Focus group discussions for the project (see later this chapter) have shown that some young people are afraid that their visit will be reported back to their family if they are seen at the surgery. Some teenagers do not believe that their visit will be held in confidence. In this, the computer is sometimes the problem. There is the perception that everyone in the surgery will know what someone has come in for and that parents may see what is on the computer. Many comments show that young women, especially, would prefer a female doctor. (See Table 29 below.) The female doctors that they have seen receive very high praise.

Table 29 I would prefer to see a doctor who is the same sex (by age and sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Prefer to see same sex Dr	Agree	69 65.7%	57 62.0%	126 64.0%
		Neutral	19 18.1%	13 14.1%	32 16.2%
		Disagree	12 11.4%	19 20.7%	31 15.7%
		Don't know	5 4.8%	3 3.3%	8 4.1%
	Total		105 100.0%	92 100.0%	197 100.0%
Male	Prefer to see same sex Dr	Agree	17 56.7%	7 29.2%	24 44.4%
		Neutral	4 13.3%	4 16.7%	8 14.8%
		Disagree	5 16.7%	11 45.8%	16 29.6%
		Don't know	4 13.3%	2 8.3%	6 11.1%
	Total		30 100.0%	24 100.0%	54 100.0%

Some respondents, particularly in the younger age-groups would feel more comfortable if they could attend services with a friend. (table 30 below)

Table 30 I would feel more comfortable if I could bring a friend (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Better if could bring a friend	Agree	39 37.5%	15 16.3%	54 27.6%
		Neutral	17 16.3%	21 22.8%	38 19.4%
		Disagree	35 33.7%	52 56.5%	87 44.4%
		Don't know	13 12.5%	4 4.3%	17 8.7%
	Total		104 100.0%	92 100.0%	196 100.0%
Male	Better if could bring a friend	Agree	6 20.0%	2 8.3%	8 14.8%
		Neutral	2 6.7%	5 20.8%	7 13.0%
		Disagree	13 43.3%	17 70.8%	30 55.6%
		Don't know	9 30.0%		9 16.7%
	Total		30 100.0%	24 100.0%	54 100.0%

The desire to bring a friend should be easily accommodated in General Practice. It was a noticeable feature of the pilot project drop-in clinics that teenagers often attended in groups, a practice that is more easily catered for in the drop-in arrangement. It is perhaps worrying that a substantial number of young people do not want their parents to know about a sexual health visit, although for a few, parents are the most trusted source of information and help. This was supported by the focus group discussions reported later in this chapter.

Comments: Positive comments (from question 19. Would you be comfortable coming to the doctors surgery for contraception or another sexual health matter?)

"Felt respected and doctor (female) listened and helped me - suitable for my needs".

"I've had a change doctors a lot about this because most of the doctors I've been to are male and they seem to rush through the subject and get embarrassed about it. I 'm now -with a female doctor. Very easy to talk to."

"Very informative and helpful on how to use each contraceptive".

"Yes I probably could but I would want to see a lady doctor"

"Appointments after school. The nurses are kind".

"I would be a bit embarassed but then again I probably would any way".

"If I needed help it is best to talk to someone and get the help, rather than going alone"

"feel very comfortable talking to my own doctors."

"They've probably been asked thousands of times so you shouldn't be embarrassed"

"I do for the pill but I would go to college to get condoms because it isn 't as much hassle coz I 'm at college 5 days a week. So its easier."

Negative comments

"Too public - all the doctors are male"

"Yes for contreception.... no for sexual health matters"

"It's embarrasing"

"No , But how old do you have to be. I can't see any thing that tells me about it".

"He knows my parents too well"

"Makes you feel stupid"

"It's not private, because my doctor is a family friend"

"Because I would have to go with my parents"

"I would be too embarrassed."

"Because it would come up on the computer when you next came with your Mum/Dad"

"I know the staff well (ie. socially)"

"Easier where people don't know you"

"Would be worried that my parents would find out".

"Too public"

"Because they might discuss my sexual problems with other GPs —I watch ER you know."

Where prefer to go for sexual Health Services and Why?

Asked where they would prefer to go and why, most said they would prefer a Family Planning Clinic (See Comments reproduced verbatim below). FPCs are seen as friendly and approachable and a place they are less likely to be seen. Some teenagers prefer to see a health professional they do not know. A few teenagers mentioned the school nurse or the drop-in clinic.

Comments:

Separate clinic/Drop-In/ Youth centre

"More private. Restricted to people with the same problems".

"Drop In... the ladies at the clinic are more confidential"

".. special teenage place"

"age orientated"

Prefer FPC

"More private."

"I could go from school and my parents wouldn't know about it."

"Hospital or Family Planning Centre [I know everyone at the [surgery]]."

"Because they don't know me and they specialise in being secretive"

"I've always gone to the FPC and know all the staff and they are friendly"

"It's more impersonal"

Some of those who responded may not yet need visits for sexual health matters.

"I wouldn 't get myself in that situation"

Prefer? *"Nowhere"*. Why? *"Embarrassing and you get taught in school"*.

Prefer? *"Not sure"*

"Because I want to keep it to my self" Prefer? *"Keep private"*

"I don't need to at the moment but if I need to in future I will "[visit GP].

Exploring Attitudes to "Being Seen" and Parents "Finding out" about Sexual Health Visits

Respondents were asked in closed-ended Likert type questions whether they were concerned about "people seeing me" or "parents finding out" if they went to the doctors or the Family Planning Clinic about something to do with sex. Nearly 30% of both boys and girls "agreed" that they would be concerned with being seen at the doctors (Table 31).

Table 31 I would be concerned about being seen at the doctors (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Concerned about being seen at Drs	Agree	38	20	58
			36.2%	21.7%	29.4%
		Neutral	13	14	27
			12.4%	15.2%	13.7%
		Disagree	41	55	96
			39.0%	59.8%	48.7%
		Don't know	13	3	16
			12.4%	3.3%	8.1%
	Total		105	92	197
			100.0%	100.0%	100.0%
Male	Concerned about being seen at Drs	Agree	13	3	16
			43.3%	12.5%	29.6%
		Neutral	6	5	11
			20.0%	20.8%	20.4%
		Disagree	4	15	19
			13.3%	62.5%	35.2%
		Don't know	7	1	8
			23.3%	4.2%	14.8%
	Total		30	24	54
			100.0%	100.0%	100.0%

Slightly more were concerned with being seen at an FPC. Some of, especially, the younger respondents didn't know how they felt about this (table 32)

Table 32 I would be concerned about being seen at a FPC (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Concerned about being seen at FPC	Agree	44	28	72
			41.9%	30.4%	36.5%
		Neutral	17	22	39
			16.2%	23.9%	19.8%
		Disagree	31	37	68
			29.5%	40.2%	34.5%
		Don't know	13	5	18
			12.4%	5.4%	9.1%
	Total		105	92	197
			100.0%	100.0%	100.0%
Male	Concerned about being seen at FPC	Agree	12	4	16
			40.0%	16.7%	29.6%
		Neutral	4	5	9
			13.3%	20.8%	16.7%
		Disagree	7	11	18
			23.3%	45.8%	33.3%
		Don't know	7	4	11
			23.3%	16.7%	20.4%
	Total		30	24	54
			100.0%	100.0%	100.0%

Over a third of both boys and girls agreed they would be "worried" about parents finding out if they had been to the doctors about something to do with sex. This was the case for significantly more of the young teenagers. (See Table 33)

Table 33 I would be worried about my parents finding out I had been to the doctor (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Worried about parents finding out been to Dr	Agree	49	20	69
			46.7%	21.7%	35.0%
		Neutral	15	17	32
			14.3%	18.5%	16.2%
		Disagree	35	53	88
			33.3%	57.6%	44.7%
		Don't know	6	2	8
			5.7%	2.2%	4.1%
	Total		105	92	197
			100.0%	100.0%	100.0%
Male	Worried about parents finding out been to Dr	Agree	13	5	18
			43.3%	20.8%	33.3%
		Neutral	3	3	6
			10.0%	12.5%	11.1%
		Disagree	8	16	24
			26.7%	66.7%	44.4%
		Don't know	6		6
			20.0%		11.1%
	Total		30	24	54
			100.0%	100.0%	100.0%

Roughly similar percentages would not want their parents to find out about a visit to an FPC; again there are significant age differences (table 34)

Table 34 I would be worried about my parents finding out I had been to a FPC (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Worried about parents finding out been to FPC	Agree	43 41.0%	26 28.3%	69 35.0%
		Neutral	13 12.4%	13 14.1%	26 13.2%
		Disagree	44 41.9%	49 53.3%	93 47.2%
		Don't know	5 4.8%	4 4.3%	9 4.6%
	Total		105 100.0%	92 100.0%	197 100.0%
Male	Worried about parents finding out been to FPC	Agree	11 36.7%	4 16.7%	15 27.8%
		Neutral	2 6.7%	7 29.2%	9 16.7%
		Disagree	10 33.3%	11 45.8%	21 38.9%
		Don't know	7 23.3%	2 8.3%	9 16.7%
	Total		30 100.0%	24 100.0%	54 100.0%

Taken together these different types of questions show that a substantial proportion of young people want anonymity in sexual health visits and are concerned about parents finding out about such visits. This was the case for proportionately more of the younger teenagers. These important issues need to be addressed if barriers to teenagers visiting health professionals are to be overcome.

SEXUAL ACTIVITY, CONTRACEPTION AND PREGNANCY

Slightly over half of the girls in the survey (54.4%) and about a third of the boys (35.2%) reported that they had had sex in response to the question "Have you had sex yet?". (See Table 35.)

Table 35 Have you had sex yet (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Have you had sex yet	No	60 57.7%	23 25.3%	83 42.6%
		Yes	41 39.4%	65 71.4%	106 54.4%
		Not say	3 2.9%	3 3.3%	6 3.1%
	Total		104 100.0%	91 100.0%	195 100.0%
Male	Have you had sex yet	No	24 80.0%	5 20.8%	29 53.7%
		Yes	4 13.3%	15 62.5%	19 35.2%
		Not say	2 6.7%	4 16.7%	6 11.1%
	Total		30 100.0%	24 100.0%	54 100.0%

As Table 35 shows, there are significant differences between boys and girls in sexual activity at young ages. Only 13.3% of boys 16 and younger reported being sexually active in contrast to 39.4% of girls of these ages. The percentages of sexually active girls and boys in the older age groups (17-19) are closer, with 71.4% of girls reporting that they had had sex, compared to 62.5% of boys.

Given the differences in percentages of younger girls and boys reporting that they are sexually active, the distribution of age at first sex is surprisingly similar for boys and girls. Nearly 90% of sexually active girls reported having sex before age 17, this was the case for almost 80% of the boys (Table 36 below). Although the numbers of boys are small it is noteworthy that the proportion of boys reporting that they first had sex at or before age 16 (Table 36) is much larger than the proportion of boys in this age group reported having yet had sex (Table 35). Thus boys may be exaggerating their age at first sex.

Table 36 How old were you when you first had sex by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Age at first sex	Not say	3 7.3%	2 3.1%	5 4.7%
		< 13	5 12.2%		5 4.7%
		13	6 14.6%	3 4.6%	9 8.5%
		14	9 22.0%	13 20.0%	22 20.8%
		15	12 29.3%	9 13.8%	21 19.8%
		16	6 14.6%	26 40.0%	32 30.2%
		17		6 9.2%	6 5.7%
		18		5 7.7%	5 4.7%
		19+		1 1.5%	1 .9%
	Total		41 100.0%	65 100.0%	106 100.0%
Male	Age at first sex	< 13	1 25.0%	1 6.7%	2 10.5%
		13	1 25.0%		1 5.3%
		14		1 6.7%	1 5.3%
		15	1 25.0%	5 33.3%	6 31.6%
		16	1 25.0%	4 26.7%	5 26.3%
		17		3 20.0%	3 15.8%
		18		1 6.7%	1 5.3%
	Total		4 100.0%	15 100.0%	19 100.0%

The number of sexual partners reported by boys and girls is shown in Table 37.

Table 37 The total number of sexual partners by Age & Sex

Sex			Age		Total
			16 and under	17 thru 19	
Female	Number of partners	One	19 47.5%	22 34.9%	41 39.8%
		Two	8 20.0%	13 20.6%	21 20.4%
		Three	5 12.5%	12 19.0%	17 16.5%
		Four or more	8 20.0%	16 25.4%	24 23.3%
	Total		40 100.0%	63 100.0%	103 100.0%
Male	Number of partners	One	4 100.0%	4 28.6%	8 44.4%
		Two		2 14.3%	2 11.1%
		Three		1 7.1%	1 5.6%
		Four or more		7 50.0%	7 38.9%
	Total		4 100.0%	14 100.0%	18 100.0%

Forty percent of girls and 44.5% of boys had 3 or more partners. The great majority of girls who had 3 or more partners were in the older age group (17-19), but nearly a third (N=13) were sixteen and younger. All 8 boys reporting this number of partners were in the older age group.

A small percentage of both girls and boys had had partners of the same sex, 5% of girls and 11% of boys (Table 38).

Table 38 Have all your partners been of the opposite sex (by Age & Sex)

Sex			Age		
			16 and under	17 thru 19	Total
Female	All partners of opposite sex	Yes	37	62	99
			92.5%	95.4%	94.3%
		No	3	2	5
			7.5%	3.1%	4.8%
		99		1	1
				1.5%	1.0%
	Total		40	65	105
			100.0%	100.0%	100.0%
Male	All partners of opposite sex	Yes	3	13	16
			75.0%	92.9%	88.9%
		No	1	1	2
			25.0%	7.1%	11.1%
	Total		4	14	18
			100.0%	100.0%	100.0%

Use of Contraception

The majority of both boys and girls had used contraception the first time they had sex (63.2% and 75.5% respectively.) The percentages using contraception the last time they had sex is higher (72.2% and 80.8% respectively). However only about half of both boys and girls say that they "never" have sex without using contraception. (Tables 39, 40 and 41)

Table 39 Did you use contraception the first time you had sex (by Age & Sex)

Sex			Age		
			16 and under	17 thru 19	Total
Female	Contraception at first sex	No	12	14	26
			29.3%	21.5%	24.5%
		Yes	29	51	80
			70.7%	78.5%	75.5%
	Total		41	65	106
			100.0%	100.0%	100.0%
Male	Contraception at first sex	No	3	4	7
			75.0%	26.7%	36.8%
		Yes	1	11	12
			25.0%	73.3%	63.2%
	Total		4	15	19
			100.0%	100.0%	100.0%

Table 40 Did you use contraception the last time you had sex (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Contraception at last sex	No	9	11	20
			22.5%	17.2%	19.2%
		Yes	31	53	84
			77.5%	82.8%	80.8%
	Total		40	64	104
			100.0%	100.0%	100.0%
Male	Contraception at last sex	No	1	4	5
			25.0%	28.6%	27.8%
		Yes	3	10	13
			75.0%	71.4%	72.2%
	Total		4	14	18
			100.0%	100.0%	100.0%

Table 41 How often have you had sex without contraception (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	How often have sex without contraception	Never	20	33	53
			51.3%	50.8%	51.0%
		Rarely	13	15	28
			33.3%	23.1%	26.9%
		Sometimes	2	8	10
			5.1%	12.3%	9.6%
		Often	4	9	13
			10.3%	13.8%	12.5%
	Total		39	65	104
			100.0%	100.0%	100.0%
Male	How often have sex without contraception	Never	1	7	8
			33.3%	50.0%	47.1%
		Rarely	1	4	5
			33.3%	28.6%	29.4%
		Sometimes	1	1	2
			33.3%	7.1%	11.8%
		Often		2	2
				14.3%	11.8%
	Total		3	14	17
			100.0%	100.0%	100.0%

Half of the girls had used emergency contraception (EC), 45% of these on two or more occasions (Table 42 and 43).

Table 42 Have you or your partners ever used emergency contraception (by age and sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Used EC	Yes	19 47.5%	33 51.6%	52 50.0%
		No	21 52.5%	30 46.9%	51 49.0%
		4		1 1.6%	1 1.0%
	Total		40 100.0%	64 100.0%	104 100.0%
Male	Used EC	Yes	2 50.0%	4 28.6%	6 33.3%
		No	2 50.0%	9 64.3%	11 61.1%
		Don't know		1 7.1%	1 5.6%
	Total		4 100.0%	14 100.0%	18 100.0%

Table 43 How many times have you or your partner used EC(by age and sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	How many EC used	1	11	18	29
			57.9%	52.9%	54.7%
		2	4	8	12
			21.1%	23.5%	22.6%
		3	4	5	9
			21.1%	14.7%	17.0%
		4		1	1
				2.9%	1.9%
		6		2	2
				5.9%	3.8%
	Total		19	34	53
			100.0%	100.0%	100.0%
Male	How many EC used	1		3	3
				60.0%	42.9%
		2	1	1	2
			50.0%	20.0%	28.6%
		4	1	1	2
			50.0%	20.0%	28.6%
	Total		2	5	7
			100.0%	100.0%	100.0%

(Only 7 boys answered this question, 4 of these had partners who had used EC.)

Pregnancy

Seventeen girls (16.7%) reported having ever been pregnant. (table 44)

Table 44 Have you or a partner ever been pregnant (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Ever pregnant	No	34	51	85
			85.0%	82.3%	83.3%
		Yes	6	11	17
			15.0%	17.7%	16.7%
	Total		40	62	102
			100.0%	100.0%	100.0%
Male	Ever pregnant	No	4	12	16
			100.0%	92.3%	94.1%
		Yes		1	1
				7.7%	5.9%
	Total		4	13	17
			100.0%	100.0%	100.0%

Only 1 boy reported a pregnancy. Six of the seventeen girls having had a pregnancy were age 16 or younger. Of the seventeen girls, 2 were pregnant at the time of survey, 6 had babies, 7 had terminations (one girl had 3 terminations Table 45). 3 girls had miscarriages.

Table 45 Have you or your partner had a termination (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Had a termination	No	3 50.0%	7 63.6%	10 58.8%
		One abor.	3 50.0%	3 27.3%	6 35.3%
		Three abor.		1 9.1%	1 5.9%
	Total		6 100.0%	11 100.0%	17 100.0%
Male	Had a termination	No		1 100.0%	1 100.0%
	Total			1 100.0%	1 100.0%

USE OF SEXUAL HEALTH SERVICES

Teenagers were asked a number of questions about use of different health services for a "sexual health matter" (SHM) defined in the questionnaires as "anything to do with sex - advice, pregnancy tests, emergency contraception, condoms, unplanned pregnancy, STIs etc." The numbers and percentages of girls and boys using different services are shown in Tables 46-50

Table 46 Have you been to a doctor for a SHM (by age and sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Been to Dr for SHM	Yes	28 27.5%	52 56.5%	80 41.2%
		No	74 72.5%	40 43.5%	114 58.8%
	Total		102 100.0%	92 100.0%	194 100.0%
Male	Been to Dr for SHM	Yes	1 3.2%		1 1.8%
		No	30 96.8%	24 100.0%	54 98.2%
	Total		31 100.0%	24 100.0%	55 100.0%

Table 47 Have you seen a nurse for a sexual health matter (SHM) (by Age or Sex)

Sex			Age		
			16 and under	17 thru 19	Total
Female	Been to nurse for SHM	Yes	5	6	11
			13.5%	15.0%	14.3%
		No	32	34	66
			86.5%	85.0%	85.7%
	Total		37	40	77
			100.0%	100.0%	100.0%
Male	Been to nurse for SHM	No	13	12	25
			100.0%	100.0%	100.0%
	Total		13	12	25
			100.0%	100.0%	100.0%

Table 48 Have you been to a FPC for a SHM (by Age & Sex)

Sex			Age		
			16 and under	17 thru 19	Total
Female	Been to an FPC for SHM	Yes	20	30	50
			19.4%	32.6%	25.6%
		No	83	62	145
			80.6%	67.4%	74.4%
	Total		103	92	195
			100.0%	100.0%	100.0%
Male	Been to an FPC for SHM	Yes	1	3	4
			3.2%	12.5%	7.3%
		No	30	21	51
			96.8%	87.5%	92.7%
	Total		31	24	55
			100.0%	100.0%	100.0%

Table 49 Have you been to a Teenage Advice Clinic (TAC) for a SHM (by Age & Sex)

Sex			Age		
			16 and under	17 thru 19	Total
Female	Been to TAC for SHM	Yes	1	2	3
			2.4%	4.1%	3.3%
		No	41	47	88
			97.6%	95.9%	96.7%
	Total		42	49	91
			100.0%	100.0%	100.0%
Male	Been to TAC for SHM	No	21	15	36
			100.0%	100.0%	100.0%
	Total		21	15	36
			100.0%	100.0%	100.0%

Table 50 Been to school nurse for SHM (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Been to school nurse for SHM	Yes	6	6	12
			5.7%	6.5%	6.1%
		No	99	86	185
			94.3%	93.5%	93.9%
	Total		105	92	197
			100.0%	100.0%	100.0%
Male	Been to school nurse for SHM	Yes		3	3
				12.5%	5.5%
		No	31	21	52
			100.0%	87.5%	94.5%
	Total		31	24	55
			100.0%	100.0%	100.0%

About 40% of girls had been to the doctor for a sexual health matter in contrast to a single boy.

A quarter of girls had been to the FPC for a SHM, 4 of the 5 boys had visited an FPC. Three girls had been to a TAC, no boys. Surprisingly few girls or boys had been to the School Nurse for a SHM, only 12 girls (6.1%) and 3 boys.

There were substantial differences by age in girls having seen a doctor or visited an FPC for a sexual health matter. (Numbers for boys are too small to analyse.) About a quarter (27.5%) of the younger girls (16 and under) had seen a doctor for a SHM in contrast to over half (56.5%) of the older girls. Similarly while 19.4 % of the younger girls had visited an FPC, this was the case for 32.6% of the older girls. Younger girls were as likely as older girls to have seen the school nurse but these numbers are very small.

Teenagers were asked if they had heard that there are "Teenage Advice Clinics in some doctors' surgeries which provide sexual health information and services". Table 51 shows overall results.

Table 51 Did you know about TAC (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Did you know about TAC	No	80	69	149
			78.4%	75.8%	77.2%
		Yes	22	22	44
			21.6%	24.2%	22.8%
	Total		102	91	193
			100.0%	100.0%	100.0%
Male	Did you know about TAC	No	20	18	38
			69.0%	81.8%	74.5%
		Yes	9	4	13
			31.0%	18.2%	25.5%
	Total		29	22	51
			100.0%	100.0%	100.0%

A larger percentage in the case practices had heard of the clinics, despite very few having used it. 30.6% of teenagers in TAC practices, compared to 17.4% in other practices, had heard of the service. However only 11.4% of teenagers in the TAC practices knew when the clinic was open. (table 52)

Table 52 Did you know when TAC was open (by Age & Sex)

Sex			Age		Total
			16 and under	17 thru 19	
Female	Did you know when TAC was open	No	6	16	22
			85.7%	88.9%	88.0%
		Yes	1	2	3
			14.3%	11.1%	12.0%
	Total		7	18	25
			100.0%	100.0%	100.0%
Male	Did you know when TAC was open	No	6	3	9
			85.7%	100.0%	90.0%
		Yes	1		1
			14.3%		10.0%
	Total		7	3	10
			100.0%	100.0%	100.0%

Asked where they would prefer a teenage sexual health clinic to be based, over half of both girls and boys preferred it based at the GP, a fifth of the girls and about 15% of the boys preferred the FPC. As might be expected some of the younger girls and boys preferred a school based service, 18.6% of the younger girls and 25.0% of the younger boys.

A large number of respondents commented on "how health services for teenagers could be improved, especially for their sexual health needs". Many of these comments are reproduced verbatim below:

"More local places"
"Somewhere that is more accessible, but private so people can go without others knowing if they want to".
"No, because this is a very rural area. There should be more FPC in local towns that are open more often."

"Helpers could be more our own age."

"I do not think they need improvement. I have always been treated wonderfully when I have had to discuss sexual health etc. As long as teen's are assured confientiallity I am sure it will be fine."

"More teenage clinics. The drop in clinics need to be open every day. You should be able to go to your school nurse."

"A more variety of places to go, somewhere that is not too formal ie. doctors. Some teenagers may prefer to go somewhere more open & laided back ie. special teenager clinic"

"More advice and better support, able to see a woman. I feel males need to be made more aware of contraception and the safety of it."

"Open more teenage clinics, perhaps near by senior schools so we could drop in with our friends and not feel so embarrased and it's important to have younger staff."

"Make absolutely certain that everything is totally confidential. Be much more open about sex in teenagers in the heath centres. People seem embrassed talking about sex"

"My local Casually Unit in (xxxxxx) require you to discuss your illness or condition in the reception for everyone to hear."

Doctors are often older, you sometimes get the impression they don't take your problem or worry as seriously as a younger person does."

"They only real place teenagers can go is their GP if the want no complications (ie. their parents not knowing). If you have no worries and aren't scared and know what to expect its fine. If you are nervous going to the FP may be a scary task"

"More awareness of places to go. Younger staff working in health services."

"They could put up some more special teenage clinics where teenagers would fill more comfortable."

"Health personal should be aware that teens are sexually active and ask them in private if they come for consultation if they have any concerns. Treat them like adults not like children who are doing something they shouldn't be."

"We need special Teenage clinics in each town".

"Most teenagers don't like to talk to someone about their sexual health needs, a freephone number which doesn't show on your phonebill would help because you'd feel more confident about talking about issues."

"I would like to know where the nearest GUM clinic is & also when Family Planning Clinic is open. We need to be more aware of the services available."

"Personally I wouldn't know where to go to get sexual advice in my area except through my GP which I have already said would be very uncomfortable. The school nurses are also not very helpful and probably wouldn't be willing to talk about such things anyway. I wouldn't really know where to go and end up having to get over my embarassment and visit my GP Although girls would prefer to talk to a <u>woman!!</u> And not always men."

"I think maybe there should be a special room, or person for these issues. It would easier and more comfortable for a girl to have a woman doctor and a boy to have a man."

"I think teenagers don't like to go to family doctors because there scared there parents will find out even though they don't get told + even the sex of the doctor can put some teenagers of. So maybe something like making them more aware there parents won't find out + even being told if your not comfortable with the sex of your doctor then you can change"

"We need more advice when we are younger in school. In Holland they are taught about sex at a lot younger age this seems to lower the child pregnancy rate."

"I don't think it does need to be improved its just the teenagers who have to have more confidence in coming to the doctors."

"I would really like for young people to be made much more aware of the dangers of sexually transmitted diseases. Show that there is not need to be embarrassed and it is highly urgent that you must get it soon to a.s.a.p.! Teach them not to be afraid of discussing condoms etc. with partners - like I said, if they're old enough to be having sex they must accept every responsibility that comes with it. I feel very strongly about all this as I have had the unpleasant experience of an STD and felt embarrassed. I may now be infertile and I wish I could stop other young people risking their future the way I did, for the sake of a trip to the doctor."

"When I have had to visit the family planing clinic I found them completely patronising. The staff consists of over 50s who still think sex before marriage is the world greatest sin and so look down at you and I didn't feel I could ask them anything and I have never been back and don't plan to!"

"Maybe setting up a contraceptive clinic within school or at local youth centres. Education about sexual issues needs to be broader and more detailed at school."

"Be very discreet and informal, it would also be preferable if the staff re younger -people we could relate to."

"Advertising - confidentiality needs to be expressed more. Accesibility - so every teenager in the country can get to it some how so there is no excuse."

"Free condoms easier to get hold of."

"Make contraception & emergency contraception easier to get"

"School sex education needs to be improved I feel I hardly learnt anything from mine. Possibly individual chats with a teacher or school nurse, I felt awkward discussing it in from of the whole class."

"Have condoms readily available so that you do not have to ask the family Dr for them. Let them know that if you think you have an STD then it's better to get it checked out and that it is nothing to be ashamed of."

"Teenagers need to know that they can g some where if they have a problem or need advice, clinics should be advertised more (like times etc.) cause I only heard about the clinic times by word of mouth by a friend. They should be more welcoming to teenagers, so they can confide in some other than a friend. They also should be open a little more, so that there not restricted to a time they go"

"During sex education in school condoms should be given out so that boys can practise putting them on correctly. Also boys should be told to go for regular check ups exactly the same as women when they have to have smear tests. Get teenagers that have had sexual problems to talk to teenagers"

"I think everything is OK with this area but young people should know more about the pregnancy is not a game and not a fashion garment"

"More posters should be desplayed about the services available, they should stand out & not look boring then, teenagers will read them"

There is a clearly expressed need for more advice and education on sexual health, especially at young ages. More advertisement of sexual health clinics is clearly needed. Again some teenagers demonstrated that they need reassurance that their parents will not be told about sexual health visits. More teenage clinics and drop-in clinics are asked for and some young people would like to see younger staff. A number of teenagers expressed concern that knowledge of STIs in this age group is inadequate.

Preferences for Sexual Health Service Providers

Respondents were asked where they thought "teenagers would prefer to get" specific sexual health services. The services comprise free condoms, emergency contraception, the contraceptive pill, pregnancy tests and tests for STIs. The question was arranged as a matrix as shown in Tables 53 and 54 overleaf.

In Survey 1, respondents were asked to put a single tick in each row. However, over a quarter ticked more than one response. For Survey 2, the question was changed to allow for multiple ticks in each row. A somewhat larger percentage (about a third) ticked more than one response in this survey. The single responses from Surveys 1 and 2 are combined in Table 53. Multiple responses are combined in Table 54. The two tables show the numbers and percentages of responses for girls and boys; girls responses are in bold type.

TABLE 53 Preferred Providers of Sexual Health Services - Girls and Boys Giving a Single Response for Each Service. [Ns (%): Girls in Bold]

	Hospital	School Nurse	GP/Doctor	Family Planning Clinic	Special Teer Clinic
Free Condoms	**0 (0.0)**	**20 (14.4)**	**19 (13.7)**	**52 (37.4)**	**36 (25.9)**
	1 (2.6)	4 (10.5)	1 (2.6)	8 (21.1)	16 (42.1)
Emergency Contraception / Morning After Pill	**4 (13.1)**	**10 (7.8)**	**43 (33.6)**	**50 (39.1)**	**20 (15.6)**
	3 (7.7)	4 (10.3)	10 (25.6)	7 (17.9)	14 (35.9)
The Pill	**1 (0.7)**	**7 (4.8)**	**90 (62.1)**	**29 (20.0)**	**17 (11.7)**
	1 (2.8)	4 (11.1)	14 (38.9)	6 (16.7)	11 (0.6)
Pregnancy test	**1 (0.8)**	**8 (6.1)**	**41 (31.3)**	**40 (30.5)**	**24 (18.3)**
	4 (12.5)	3 (9.4)	10 (31.3)	3 (9.4)	9 (28.1)
Test for a sexual transmitted infection	**21 (14.3)**	**3 (2.0)**	**66 (44.9)**	**30 (20.4)**	**27 (18.4)**
	7 (20.0)	1 (2.9)	14 (40.0)	5 (14.3)	7 (20.0)

TABLE 54 Preferred Providers of Sexual Health Services - Girls and Boys Giving Multiple Responses for Each Service. [Ns (%): Girls in Bold]

	Hospital	School Nurse	GP/Doctor	Family Planning Clinic	Special Teenage Clinic	Youth Club
Free Condoms	**4 (2.7)**	**22 (14.9)**	**20 (13.5)**	**40 (27.6)**	**46 (31.1)**	**14 (9.5**
	3 (6.5)	1 (2.1)	9 (19.1)	12 (25.5)	16 (34.0)	5 (10.6
Emergency Contraception / Morning After Pill	**14 (8.5)**	**28 (17.1)**	**38 (23.2)**	**44 (26.8)**	**34 (20.7)**	**4 (2.4)**
	5 (11.1)	5 (11.1)	10 (22.2)	9 (20.0)	10 (22.2)	6 (13.3
The Pill	**5 (4.0)**	**13 (10.3)**	**42 (33.3)**	**38 (30.2)**	**25 (19.8)**	**2 (1.6)**
	4 (10.8)	2 (5.4)	11 (29.7)	10 (27.0)	7 (18.9)	3 (8.1)
Pregnancy test	**11 (7.0)**	**19 (12.1)**	**37 (23.6)**	**44 (28.0)**	**36 (22.9)**	**4 (2.5)**
	7 (15.2)	6 (13.0)	13 (28.3)	9 (19.6)	8 (17.4)	1 (2.2)
Test for a sexual transmitted infection	**28 (22.4)**	**1 (0.8)**	**38 (30.4)**	**32 (25.6)**	**23 (18.4)**	**2 (1.6**
	13 (27.1)	1 (2.1)	15 (31.3)	6 (12.5)	12 (25.0)	1 (2.1)

Free Condoms

Looking first at Table 53, nearly 40% of girls preferred to get condoms from the FPC, a quarter from the Teenage Clinic, and fewer than 15% ticked either School Nurse or the GP. Boys, on the other hand (note small numbers though) preferred the Teenage Clinic and the FPC (4 boys ticked the School Nurse and only 1 the GP).

However, when teenagers ticked several preferences, proportionately more girls included the Teenage Clinic as a provider and more boys the GP. The School nurse is not seen as a preferred provider by many teenagers nor is the Youth Club (See Table 54 percentages are to the base of all responses rather than respondents.)

Emergency Contraception

A different pattern of preferences emerges for EC. As Table 53 shows, the GP and the FPC are seen as the preferred providers by the girls who gave only one response, 33.6% and 39.1% respectively. Boys, gave as preferred providers the Teenage clinic (35.9%), the GP (25.6%) and the FPC (17.9%). Given how rarely the Teenage Clinics are open, under the present schemes, this suggests that boys may not be certain what these clinics are. Surprisingly few girls (7.8%) or boys (10.3%) preferred the School Nurse.

Where respondents chose several providers, girls were much more likely to indicate that the school nurse was a preferred provider (17.1% ticked "School nurse".) The hospital was also given as a preferred provider by more girls and boys. Proportionately fewer girls chose either the GP or the FPC where multiple providers were reported.

Contraceptive Pill

For the contraceptive pill, slightly over 60% of girls indicate that teenagers would prefer to see their GP. A fifth of the girls chose the FP clinic as the preferred provider. This is consistent with focus group discussions (see later this chapter), which also suggested that the GP is preferred where medical advice and continuity of care may be needed. Boys were more likely than girls to see the Teenage Clinic or the School nurse as a preferred provider. Again where multiple responses were given, the preferred providers change. Only a third of girls chose their GP, a larger percentage chose the school nurse, the Teenage Clinic and the FPC. Boys' responses, on the whole, are broadly similar to girls.

Pregnancy Tests

A number of different providers were ticked as a preferred sources of pregnancy testing both by those giving one response and those giving more than one. About 30% of the girls indicated the GP and for another 30% the FPC was the preferred provider. A fifth indicated preference for the Teenage Clinic. Boys too preferred the GP and the Teenage Clinic. Girls giving multiple responses show a similar distribution to those giving single responses, with again a greater preference for the school nurse.

Tests for STIs

Forty five percent of the girls giving a single response for preferred provider of tests for STIs chose the GP. A fifth preferred the FPC. About a fifth of both boys and girls preferred the Teenage Clinic. The hospital is chosen by proportionately more boys and girls than for other sexual health services. Over a fifth of both girls and boys giving multiple responses chose the hospital as one of the preferred providers and showed less reliance on the GP.

Summary

Preferred providers for sexual health services differ for boys and girls. This may be explained by girls having a better understanding of what is available from each provider. Boys show greater preference for the Teenage Clinic, but this may not be informed by knowledge of how frequently these are open. The substantial proportion of multiple responses suggest that a significant minority of teenagers do not want to be tied to a single provider for these services. The School Nurse is not yet seen as an important preferred provider even for condoms and emergency contraception. For the majority of girls the GP and the FPC are the important preferred providers.

CONCLUSIONS

This survey, carried out in 10 General Practices with 253 teenagers, offers valuable insights into their evaluations, perceptions and use of health services. Although findings must be treated with caution because of the low response rate, the range and types of responses and the detailed comments on many of the questions make this survey a useful contribution to the descriptive project. Differences shown by age and sex of respondents

suggest that this group of teenagers has captured much of the variation in teenagers' attitudes and behaviours.

However, teenagers who are extremely unhappy with or reluctant to use their practice may be under-represented. Young people do not speak with one voice, as is shown here, but on the whole the data suggest that teenagers are highly satisfied with their practices. However there are some areas where improvements can be made. GPs received very high ratings generally, both in the quantitative questions and the comments. There may be room for improvement in giving teenagers information in a way that is "easy to understand". Nurses, too, could take more time to talk to teenagers and perhaps use visits to them to advertise some of the services the practices provide. The data suggest that many young people have little contact or very short visits with nurses and, perhaps, do not see them as a resource. The one area where a great number of teenagers were critical of their practices is that they are not seen as "teen-friendly", especially in the provision of reading material appropriate for teenagers.

Teenagers are less comfortable with their GPs and attending their practices for sexual health matters. This is especially the case for younger teenagers. This is the result of a combination of factors, including knowing their GP too well in some cases and not well enough in others. A large number of teenagers would prefer a female doctor and many of those that had female doctors were highly complimentary about the care they received. Given that many teenagers would like to see a female doctor, something that is difficult to provide in the short-run, nurses may be an underused sexual health resource.

Teenagers are also concerned about "being seen" attending their practices for a sexual health matter. They are concerned not only with perceived lack of confidentiality but also lack of anonymity. For some, the Family Planning Clinics are preferable. A third of the older girls had visited an FPC. FPCs received very positive comments from a number of these respondents.

Many teenagers express concern that their families will be told or discover that they have had a sexual health visit. Reassuring young people about this is something that can be communicated by health professionals and could usefully be communicated in the leaflets that teenagers are asking for on sexual health matters.

The Focus Group Discussions

Using Focus Group Discussions

Focus groups are an established research technique for gathering in depth information. In particular, this method allows the researcher to draw out the opinions of participants and in turn reveal the thinking behind the way these opinions are formed. The group format allows both consensus and disagreement to be revealed through the discussion of the participants, with guidance of the topics provided by the moderator who otherwise offers relatively little interference.

FGDs are not appropriate for establishing the precise extent of knowledge among individuals but rather allow the groups to discuss how and why they have established various opinions. As groups talk about issues presented to them, the areas of concern and interest become apparent and there is scope for seeing the extent of agreement and disagreement about a particular topic. In some cases, one or two people in a group may provide accurate information, for example about emergency contraception, which gives a cue to other participants. FGDs provide rich qualitative information about the processes that the participants undergo in coming to an opinion about a situation or a service under discussion. For this reason they have been a crucial source of information for the descriptive survey.

The methodology used for the FGDs has been described in Chapter 2. The scenarios used could be considered to be ranked in "seriousness" from thinking of having sex for the first time, to having an unplanned pregnancy. The scenarios provided a way for the participants to show which services they were aware of, and what they thought about them. It also showed which circumstances they considered a health professional to be an appropriate source of information. Where necessary, the moderator probed to find out what they thought about the people or services they mentioned and how much they knew about them.

At the end of the discussion, participants were asked to complete a one-page questionnaire that asked about sexual experience and use of sexual health services. (This was not permitted in the Redton under sixteen girls' group.) All other details obtained are shown in Appendix 1.

All the discussions were tape recorded, although technical problems lead to no tape being available for Blueham boys 16+ and Blueham girls 16+ and the second half of Greenham boys 16+. In these cases detailed notes were made as soon as the tape failure was revealed. Once the discussions had been transcribed they were read over by two members of the research team who identified themes from the data. These themes were used to make a framework through which the scripts were interpreted. All members of the research team were then allocated a number of themes and scenarios, which they read and analysed, identifying key quotes and further themes. These were then collated and all members agreed on the final report.

Attitudes towards different service providers tended to differ both within and between the groups. This was influenced both by personal experiences and perceptions and by the services that were available in each location. The range of services available locally in each area is given in the description of the "case" practice areas in chapter 2.

Presentation of FGD results

As described above, key themes were drawn from the transcribed data and used to analyse the results. A brief summary of the data obtained within each scenario is given below and the bulk of the data is then analysed under each theme. The scenarios were:

- Sex education in school (used as an introduction to the FGD process)
- Thinking of having sex for the first time.
- Wanting to find out more about contraception.
- Wanting to get condoms free of charge.
- Worried about having caught something from having sex.
- The condom broke.
- A "friend" had an unplanned pregnancy.

The themes were:

- Theme 1. Perceptions of service providers (GPs, FP clinics, School nurses and Young Peoples Services)

- Theme 2. Sources of advice and guidance (teachers, parents, youth workers, friends, boyfriends and girlfriends)

- Theme 3. Barriers to service use (internal barriers, external barriers)

Some repetition of quotes is evident because some quotes are revealing in more than one context. For example, issues to do with quick access to the doctor may appear in the section about the scenario related to Emergency Contraception, because this is where the subject first emerged, as well as in the discussion of GPs because this was perceived by some participants as a barrier to their use.

Quotes from the groups are presented verbatim to preserve the personality and character of their comments. However, some of the "er" and "um" content has been removed for easy reading. Where some of the content has been omitted, this is indicated by a series of dots, though omissions do not alter the substantive content of what is being discussed. Where several speakers are presented in the same quote, a hyphen at the beginning of the line indicates a new voice. In these cases, voices may interrupt each other and a series of dots at the end of one line and then the beginning of another indicates that the same speaker continues over the lines. Words in square brackets have been added to clarify the meaning of some sentences; they usually replace personal pronouns or other words that are unclear out of context. Moderator's comments are indicated by "Mod" at the start of a line. All names have been changed to preserve the anonymity of the speakers and those they are discussing.

Sex education

As an ice-breaker, and to get the groups used to talking about issues related to sex in a way which was non-threatening, the groups were first of all asked to describe any school sex education that they might have had. It was felt that this topic would give them an opportunity to air their views on a topic that they had all experienced without initially asking questions which may relate to their personal experience of sexual and reproductive health matters. In reality, some groups had much to say about their sex education and so their responses are discussed. The different scenarios are then introduced.

Details of the scenarios

The scenarios presented were designed to explore realistic situations that sexually active teenagers may encounter. In each case, the groups were asked to imagine what they would say to a friend who came to them with a particular problem: what advice they might give them, and if they would suggest their friend went to seek help from anyone else.

Scenario 1

The first scenario concerned a friend who was thinking of having sex for the first time and who was a bit nervous about it and wanted some advice. The aim was to learn about first sexual experiences, and young people's opinions about how and when this might occur

Scenario 2

The groups were next asked to consider what advice they would give to a friend who wanted to find out more about different kinds of contraception. This was intended to get the groups to discuss the sources of information they were aware of (including health services) and begin to discuss which they found appropriate and why. It was here that most groups began to discuss the relative merits of different sexual health service providers – the GP and the FPC being the most commonly mentioned. All of the groups knew of somewhere they could go. Some participants also mentioned youth services, school nurses, friends, family and youth workers as people they would turn to for information about contraception. This data is mostly presented under the appropriate "theme". Much of what emerged as concerns about these different sources of help was relevant to this and other scenarios. There were no particular issues that emerged relating solely to contraception.

Scenario 3

The third scenario asked about a friend who wanted to get hold of some condoms. If the groups initially mentioned only places to buy condoms, they were prompted to think of places that their friend could get free condoms if short of money. This situation was included for discussion because condoms are a particularly popular form of contraception for teenagers

Scenario 4

In the fourth scenario, a friend thought that they might have caught something from having sex. The question was deliberately vague to see how the groups interpreted the

idea of having "caught something". It provided an opportunity to explore which services teenagers knew about in relation to an STI, and which diseases they knew about.

Scenario 5

In the fifth scenario, groups were presented with a friend who had had sex with a condom last night, but the condom had broken. This was intended to establish levels of knowledge about Emergency Contraception (EC) it's use, time limits and availability. EC is available from GPs, FPCs and some hospital A&E departments. Hormonal EC can be used up to 72 hours after unprotected sex, or an IUD can be inserted up to 5 days afterwards. It was clear from many of the girls groups that high levels of personal experience informed their responses.

Scenario 6

In the sixth scenario, a friend thought that she was pregnant. This focused on the groups' attitude towards teenage pregnancy and how they viewed the options faced by a young pregnant woman. In addition, it was hoped that the groups would discuss who they felt was an appropriate source of help with decision making in this situation. In the boys' groups, they were asked to think what advice they would give to a friend who thought his girlfriend was pregnant.

Summary of method

These six scenarios were used in the focus groups to precipitate discussion about the different services that teenagers were aware of in their local area. They were prompted to discuss specific aspects, such as where they were, how often they were open, the quality of staff, how easily they could access the services, and whether or not they felt that teenagers used the services. This led to an evaluation of what they wanted and whether or not these needs were being met in their locale. In addition, participants discussed their attitudes towards the different situations that their "friend" found themselves in.

Sex education in school

The groups were asked to describe what kind of sex education they may have had, its content, who had taught them and how useful they found it. Most of the group participants remembered receiving some kind of sex education in the classroom, although the school year in which they received it varied. Some remembered only

primary school talks or sessions on puberty in their first year of secondary school, whilst others recalled their most recent sessions, usually in Year 9 or 10. Most remembered having seen a video in Year 7 or 8 that covered pubescent changes and the mechanics of reproduction. Subsequent sessions took place in biology lessons, in RE or in PE classes or in some combination of these. Teachers mostly took the classes, although a nurse (either the school or college nurse) or someone from the Family Planning Service gave some sessions. Those from Redton had an intensive programme (APAUSE[83].) involving outside speakers and peer educators.

Girls may also have had a separate lesson in primary school or first year of secondary school with a nurse ("the Tampax lady") who discussed periods. Most of the groups mentioned this. The boys were not involved and most reported that they either continued with normal lessons or in a couple of cases, played football whilst a nurse discussed menstruation with the girls:

> *"We only got split up once and we were just talking about periods, but that's back in Year 7. We got given a free little towel."*
>
> Redton Girls 16+

> *"They get Tampax at school. It's not fair....they get little goody bags."*
>
> Blueham boys <16

> *"The boys just did something else. We didn't have talks did we? The girls went off to do like periods and stuff.."*
> *-We just had normal lessons.*
>
> Greyville boys 16+

Several of the boys' groups seemed to resent this extra attention – particularly as this was a separate lesson only for girls, and the girls often got free gifts in the form of towels or tampons.

The separation of boys and girls, with the boys often not given any equivalent session, marks puberty and sex as something uniquely relevant to the girls and from which boys are excluded from a very early stage. The National Curriculum emphasises the mechanics of sex and reproduction, and it is the female reproductive system that receives most attention throughout much sex education. This early experience of the boys being

excluded from any information about female puberty may contribute to a general perception that sex, contraception and reproduction are "women's issues".

One Redton group complained with some indignation that they had been given information about women being at risk of infection if they wiped their bottoms from back to front.This was not felt to be appropriate:

> *"They were telling us boys how girls wipe themselves! What's the point of that? It's totally irrelevant innit?.....I don't want to know how girls wipe themselves."*
>
> Redton Boys 16+

This group was one of the few that felt separate classes for boys and girls were appropriate.

Most groups did not regard separate sex lessons as a good idea, although some thought it might help for the early, factual parts of the lessons followed by mixed lessons for discussion. On the whole, most wanted mixed groups for sex education:

> *"I think [single sex lessons] only makes it more divided. I mean, I think a lot of girls find it difficult to talk to boys about it already and I think by splitting you up when you're learning about it, you just don't appreciate both sides."*
>
> Brownton/Pinkham girls 16+

This quote shows an understanding of sexual relationships as complex and interactive, involving different expectations and viewpoints. There is an expectation among young people that sex education should improve communication and understanding between boys and girls. However, in both girls' and boys' groups there was a feeling that the immaturity of the opposite sex was a barrier to learning. In some cases, this was used to support the idea of at least some single sex lessons:

> *"You've got to really, 'cos the boys are more immature."*

"I think its better to start off separately, do the facts and then bring a mixed group in and you can talk about it 'cos you've already done it. When you're younger it gets a little bit embarrassing with the boys".

Greyville girls 16+

"It's just like "Ah look at those tits!" ... it's really pathetic...The boys in our year are very immature....I think the girls should be allowed to learn about the boys without the boys going around going "Oh yeah, mine's like that!" because that's what they're like. The are really big headed about it"

Greenham Girls <16

"You've got all the girls in the background giggling, so you try and get it over and done with really quickly, all the dirty bits."

Greyville Boys <16

Clearly there are negative as well as positive elements to learning in mixed sex groups. Aside from discomfort and embarrassment, the girls in the second quote seem to be at risk of intimidation from the boys in their class.

Several boys' groups mentioned that they felt their peers required that they didn't take sex education too seriously in school:

"It wasn't anything special...it's just a mess around really at the time."

Pinkham/Brownton boys 16+

"I think it was just listening and giggling really".

Greyville boys 16+

"Most of them just use it, its an excuse to get out of a lesson I think".

"At that age. Just with your mates and that".

"Yeah. You always got to act hard don't you? And start like laughing."

Redton boys 16+

The last quote particularly suggests that there is considerable peer pressure among boys not to show interest in sex education lessons. Where there are genuine questions to be asked about the information they need, boys are unlikely to be able to do so.

Content of sex education

The sex education videos seen around Year 7, dealing with puberty and the biology of reproduction, were well remembered by most of the groups despite being seen some years ago. This may be because it was the first sex related class they had. Their content was often recalled with some amusement that may also help explain why it stuck in the memory:

"People running around on the beach"

"Yeah, playing naked volley ball..."

Greenham Girls 16+

"We used to have to watch all these videos of men in swimming pools pretending to be sperm."

"It was a woman sat on a heart-shaped blow-up thing in the middle of a swimming pool and all these men swimming up seeing who could get to her first!"

Brownton/ Pinkham Girls 16+

By contrast, sessions in later school years seemed to be recalled with less clarity. The exception was another "novelty" item recalled by most groups – a condom demonstration in which a teacher or nurse rolled a condom onto (variously) a "banana", "boiling tube" or "glass bottle". They also remembered being told about different kinds of contraception ("the coil and all that lot") though in further conversation their recall of the methods, other than the condom and the pill was often hazy.

Whilst all had received information about reproduction, the context in which most sexual activity occurs was often missing from the situations with which the teenagers were presented. Asked what they thought was missing, several groups mentioned emotions and relationships as being absent from their sessions.

"The actual pleasurable side of things and feelings and emotions and stuff like that."

Most groups felt that there should be more space for discussion about how people feel, both emotionally and physically, when they engage in sexual relationships.

The groups, admittedly jokingly in some cases, also felt that they should be given more frank information about sex itself, or "how to do it" – different acts and techniques. They described a role for sex education that is closer to "sexuality education" than the traditional "birds and bees" approach. One boys group jokingly recommended "Someone to have a go on!" whilst a girls group talked about women's magazines which offered ideas as to the "position of the week" as an example of frank information. Basic biological information no longer feels appropriate to these teenagers who have been exposed to increasingly sophisticated expectations of sexual activity. Other groups wanted somewhere where playground language and practical information met:

> *"Boys like ask you to do things to them like toss them off, and there are people that don't know what they mean...everyone reckons they know what it means but some people don't, they just say it."*
>
> Blueham girls <16

This quote also recognises the anxiety that many people feel about exposing their own ignorance about sexual matters. Playground banter may make this difficulty particularly acute. The vocabulary available to discuss sexual matters may be limited, and this makes frank discussion about sex, expectation and desires, as well as personal safety, difficult to negotiate. Many magazines aimed at young people contain tips about improving your sex life, and many respondents, both boys and girls, clearly felt that this information about being a good lover should be part of their education:

> *"What's the latest moves?"*
>
> Blueham girls <16

> *"Positions!"*
>
> Greyville girls 16+

"They didn't have what like places women like and what places men like....they didn't go right into like saying, um, a woman likes to be kissed or that, that the nipple likes to be sucked and stuff like that."
[laughter]

Greenham boys 16+

These speakers envisage something that helps them to become better lovers or, better able to enjoy their own sexuality. Teenagers operate in a difficult space where they have some extremely sophisticated knowledge and information, but at the same time may be lacking basic information about sex, contraception and STIs. All of them find the balance between knowledge and ignorance difficult to negotiate, particularly among their peers. Sexual knowledge is vital currency in these teenagers' interactions.

In addition, several groups felt that there had not been enough information about the potential negative effects of sexual activity – particularly STIs, and what the effect of these might be. The reality of their possible risk for STIs is difficult to grasp for many. These teenagers wanted to be given frank information about negative as well as positive aspects of sex:

"I don't know of anything about the consequences of what happens. You don't actually hear the consequences of your actions could be this, this, this and this."

Greyville girls <16

"We should have videos of them telling you, like people that's caught [HIV], being on TV and like showing what happens and stuff like that. So you can actually see that it's true."

Greyville boys <16

The groups were also asked whether or not they had discussed homosexuality or abortion. None reported having discussed homosexuality. Those who had discussed abortion had usually studied it as a moral issue either in their RE or PE lessons.

Many teenagers in the focus groups felt that their sex education was characterised by being "too little, too late". Most did feel they had got at least something from their sex education in school - some thought that they had learnt useful information and all thought that schools should continue to provide it. However, participants commonly described it as "boring" or "unhelpful".

"It could be done younger though, I reckon."

"Cos everybody knows like by the time they tell us anyway."

"It was a complete waste of time ***then"***

" If you don't know then, well."

Brownton/Pinkham Boys 16+

"We were all 15 or 16 by then, it just seemed too late to really learn anything much."

"Like I mean, you've done it by then!"
(laughter)

Greyville girls 16+

The fact that many received detailed sex education after they had become sexually active contributes to their feeling that early sexual activity is disapproved of by adults. It also means that they are often ill informed about STIs, pregnancy risks and contraception at the time they start to have sexual relationships.

Those from Redton had received an intensive program of sex education from the APAUSE team, which aims to offer a skills based approach to negotiating intimacy as well as factual knowledge. The program includes peer work and practising resisting pressure. However, some of those receiving this did not like these activities, finding them difficult to participate in, or simply thinking them unrealistic:

"We had to get up in front of the everyone and go "no".... Having to get up in front of people I don't like that."

Redton girls <16

"When we were doing APAUSE we had this woman which was teaching it and she'd say "Do you want to come up to my room?" and we had to say "No"...."
[Laughter]

..."I mean, if a girl comes and says that, and we had to say no like!..."
[Laughter]

"It was loads of students doing it as well, it wasn't like people who knew what to do."

Redton boys 16+

Although studies have suggested that peer education can be successful, the latter speaker doubted the experience and knowledge of those only slightly older than himself.
There was a sense in many groups that sex education as a whole was rushed through, without any in depth consideration of what most understood to be a complex topic. Teachers were portrayed as keen to simply get through material as quickly as possible and often as uncomfortable or embarrassed about the topic. This in turn meant that questions or discussion were actively or effectively discouraged:

"They just say "Sex" and then they kind of skip over it".

" Like "Sex is between like two lovers" and then they just leave it at that."

"And if you ask questions then it's just a yes or a no or we will move onto that later, and then they forget about it."

Greenham girls <16

" I think they rushed it too quick like, they should have spent a bit more time on it, like all the actual things that do go on...."

"They didn't spend any time on it at all, just like everything they done with us was done in 20 minutes."

Greyville boys <16

Where there is no time for discussion, there is unlikely to be any kind of forum for exploring the more difficult topics of emotion, desire and pleasure which the teenagers did actually want to discuss.

One of the most prominent aspects of sex education recalled by the groups was the embarrassment felt by those delivering the lessons.

> *"[The teacher] was very embarrassed and he was shaking when he was writing."*
>
> Greenham girls <16

> *"I think he tried to get it over as quick as possible...he didn't spend any time on anything."*

> ***Mod:*** *"Do you think the teacher was embarrassed?"*
> *"Yeah" (chorus)...*

> *"Everyone's taking the mickey out of him as well."*
>
> Greyville boys 16+

Embarrassed delivery may not allow for the relaxed atmosphere needed for discussion or questions to be fostered.

Key Points

- All of the groups had received some sex education at school and most believed that schools should offer this and that they had learnt something from it.
- All the groups were critical of what they had received.
- Embarrassment on the part of both teachers and pupils and a rushed delivery style restricted what pupils could learn and what they could discuss.
- Often information was felt to be delivered too late - after some had become sexually active.

- Many felt that the material was inappropriate and didn't address the concerns they had about what the risks of STIs were, or what contraceptives were safe and effective.
- Neither did the sessions allow them to discuss the positive aspects of sexuality – what was enjoyable, emotions and relationships.

The APAUSE team has found that young people's perceptions of how much sex education they had is not related to the accuracy of the knowledge they possess[84]. The discussion of sex education may not, therefore, give an accurate picture of the way in which the teenagers were taught, or indeed the amount of knowledge they have about sexual matters. As will be discussed later, many groups' discussions revealed significant gaps in their knowledge about contraception, STIs and services despite many protestations that they "knew it all" before receiving school sex education.

Other Sources of Information about sex

As many groups were quite dismissive of the sex education they received, they were also asked how else they found out about sexual matters. It has been shown that most young people have a number of different sources of information about sex as well as formal sex education. These include their parents (especially mothers), their friends, magazines and other media[85].

It was clear in several groups that participants felt incumbent to inform themselves about sexual issues rather than rely on official education sources such as parents or school:

"You find out for yourself."

"You've got to do it yourself"

"You find out for yourself really".

Greyville Girls <16

"You just learn it on your way, as you grow up."

Greenham Girls <16

Information about sex is gradually assimilated from a variety of sources – some more informative and accurate than others. It was interesting when talking to boys groups in particular, that many participants could not identify any specific source from which they had obtained information about sex – it rather seemed to be vaguely absorbed.

> *"It sort of comes from common knowledge though, when you grow up."*
>
> Brownton/Pinkham boys 16+

> *"It didn't learn me, didn't teach me anything 'cos I already knew what they told me, not from my parents, just from everything else, the TV and stuff like that."*
>
> Greyville boys <16

They appeared keen to show that not only were they fully informed now, but that somehow they had *always* known about sex and no one had to actually tell them about it. There is a clear pressure on boys to avoid appearing ignorant or innocent about sexual matters.

Magazines

Magazines were frequently mentioned by girls as sources of information:

> *"You read, we read, we've read about lots...in Sugar and like girls magazines."*
>
> Blueham Girls <16

> *"The problem page in Sugar..."*

> *"That one about More magazine , you know that's got like positions .."*

> *"Sex positions and stuff".*
>
> Greyville Girls 16+

> *"Every, every, every magazine you pick up has got something about [contraception]."*

"At least one magazine a month, I mean, you've got all the different types, what happens, why, how effective it is, what you can use with it and everything"

"Where to get it from."

Greenham Girls 16+

Magazines, especially those aimed at teenage girls, provide information on a number of levels, from practical information about sex and contraception, to information on how to improve ones sex life, and problems related to boyfriends, sex and relationships. Most groups who mentioned them found these both informative and interesting. However, one group also described how a teacher had confiscated such a magazine on the grounds that it was "pornographic."

Friends

For many, friends were a prime source of information. Friends were particularly important for girls who relied on friends for both practical information and emotional support. In addition, they sometimes identified an information "leader", someone who had already used a particular health service, as a key informant:

***Mod**: "So where do you get most of your information from?"*
"From each other mostly. Because more of us are finding out....we've been to the Family Planning Clinic before and got loads of leaflets from there". Redton Girls <16

"Say your friend's already been and you can ask them what they're like and that, which will help you decide whether you want to go or not"

Blueham Girls <16

Research has suggested that peer behaviour and attitudes are important predictors of contraceptive and safer sex behaviour among friends[86]. Girls who encourage their friends to use contraception and attend health services may have an important impact.

Conversations with friends could be seen as the primary source of information about sex for both male and female participants:

"You all talk about it in school as kids. Everybody discusses it with each other. All the boys talk about it, all the girls talk about it with each other, then you actually learn it from your friends and it's common knowledge where you come from. You don't actually get from the teachers 'cos you know it before you've actually had your lessons."

Brownton/Pinkham boys 16+

This speaker is keen to emphasise the irrelevance of formal sex education, particularly relating to the basics of reproduction.

However, although friends were frequently seen as a major source of information and in many cases the preferred source, the quality of what they could provide was variable:

"Sometimes they mess about."

"And tell you the wrong things, and you're like "Oh!" when you're younger."

"Its like Chinese whispers innit?"

Redton boys 16+

Groups were aware that their friends might mislead them, sometimes deliberately. In addition, some participants were wary of discussing their personal problems with friends as they might prove to be less than discreet:

"You see they'll just go round blabbing it to everyone else, whatever you say to them, anyway".

Blueham Girls <16

There was a good deal of variation in the levels of trust that respondents had in their friends. Boys especially were uneasy about asking questions of their male friends who they felt would use vulnerability as an opportunity to ridicule and tease them.

"It's like at school everyone, you all take the piss as much as you can."

Brownton/Pinkham boys 16+

"Your friends, you know, you'd get it right ripped out of you."

Blueham boys <16

Parents

For some participants, parents were also a source of information. Girls who could talk to their mothers usually described her as "open" about sex. Several of the boys mentioned their fathers as a source of information although this was often in the form of banter and jokes rather than discussions:

"Well he's a dirty bugger isn't he?....He does it joking around like."

Redton boys 16+

Fathers were rarely seen as a source of serious sex education advice. Many participants could not imagine approaching either of their parents about matters to do with sex.

Leaflets

Several groups mentioned that they had been supplied with leaflets about sex, contraception and STIs, either by the school, school nurses, youth services or from FPC consultations. However, this may not be an effective way of communicating with this age group, particularly the boys:

"Get given leaflets and stuff I think."

"Do you read them John?"
"No".

Greyville Boys 16+

"They give you leaflets. I had a quick flick through them, chuck them in your bag and forget about it."

Brownton/Pinkham Boys 16+

However, one male participant had a leaflet about EC in his bag at the time of the FGD, which he had read thoroughly after a girlfriend had used it.

For some of the girls' groups, information leaflets were seen as a useful resource:

> *"We've been to the Family Planning Clinic before and got loads of leaflets from there."*
>
> Redton girls <16

> *"If you want any information then [school nurse] will give it you in a leaflet and answer any questions."*
>
> Greenham girls <16

Key points

- The groups did have other sources of information about sex besides school sex education.
- There were clear gender differences between girls and boys. Some girls had open relationships with their mothers who were seen as a good source of information and support. For others, there are magazines and friends. Friends were usually highly valued as a source of information and support.
- For the boys, few mentioned their mother as someone they could speak to about sex, and fathers often restricted their talk to banter and jokes. There seem to be no teenage magazines aimed at young men equivalent to those the girls rely on. In addition, friends could be useful but weren't always trusted not to use any questions asked of them as ammunition to ridicule the questioner.

Scenario 1: thinking of having sex for the first time

The groups were told that a friend was thinking of having sex for the first time, and they were a bit nervous about it, and wanted some advice. The groups were asked to say what advice they would give them, and if they would suggest talking to anyone else. This was not usually considered to be a situation to be discussed with a health professional, but one they would give their friends advice about themselves. Two groups did mention the GP as someone from whom they should get contraception but in most cases this was seen as a situation in which friends would advise each other.

Just Do It?

Most groups, both boys and girls and those under sixteen, would give their friend the advice to go ahead and "do it," although this was usually qualified by being sure that they used contraception. Condom use was often indicated by euphemistic expressions such as "johnnies", "use protection" or "take precautions".

> *"Yeah, get stuck in! No only joking. Um, just tell them to go and buy a pack of johnnies or something"*
>
> Brownton/Pinkham Boys 16+

As has been discussed in the previous section, this lack of ability to articulate clearly what was needed to ensure the encounter was free from risk of pregnancy or infection may inhibit communication about condom use. One group saw that even acquiring and intending to use condoms did not guarantee their use:

> *"[Condoms] always end up in your wallet that's in your trousers that's left on the floor. Like never putting them on."*
>
> Greyville girls <16

No advice was offered as to how their friend might be encouraged to ensure that condoms were used in their first sexual encounter.

Circumstances Leading to First Intercourse

Respondents, particularly girls, also wanted their friends to be sure they wanted to have sex and were not being pressured into it.

> *"You know what you're doing, you're not being pushed into it and you are ready and he's ready and you've got contraception on you."*
>
> Redton girls 16+

> *"Go for it!"*

> *"Use protection."*

"Don't be pressured into it by him, if you don't want to do it with him then don't do it with him."

"Have a good time!"

"Make sure you use contraceptives. If he says "No I don't want to use it" say "Goodbye! Get out the door man!"

Greyville girls <16

In most of the groups, girls mentioned the possibility that their friend was being pressured to have sex. In some cases, the wording of the scenario, saying that their friend was a bit worried or needed to talk about it, implied to participants that they were not ready to have sex. If this were the case, their responses were protective of the friend, who would be advised not to do it:

"If they are not sure, then they shouldn't go ahead with it. They shouldn't; go ahead with it unless they are 100% definite its what they want otherwise they're just going to end up regretting it I think."

Greenham Girls 16+

However, the idea voiced above of being absolutely certain that their friend wanted to have sex before going ahead with this was undermined by the circumstances under which respondents thought sex might take place. This was thought particularly if under the influence of drink or drugs. The scenario prompted a debate amongst one group about who they would have sex with, and under what circumstances:

"You wouldn't be having sex if you didn't love them would you?"

"Not unless you were extremely drunk....."
"Yeah well you only have sex if you love the person really"

"No that's not true..."

"With a fuck, there's no feelings between either of you. It's, you could be friends but it's just you know...dying for it".

"Or you've just met that night."

"Either that or you've been taking drugs..."

"And a shag just, you know the same as a fuck but there is a tiny bit of feeling."

"And sex is something you do when you're drunk....making love's when you're in a stable relationship...at the end you feel comfortable. You say "I love you" and they say "I love you too.""

Greyville Girls <16

There is a tension revealed within this group between the "ideal" of sex only within the context of a loving relationship and the reality of sex occurring for other reasons – due to desire ("dying for it") or a presented opportunity, or when drunk or high. In addition, the influence of drink or drugs was recognised as one that might contribute to engaging in a sexual encounter with someone who they would not sleep with normally. Inebriation is believed to contribute to unsafe sex[87]. However, one group in this study specifically recommended getting drunk before first sex (Redton Boys 16+) as they felt Dutch courage would be required to get over any nerves.

Some groups considered that the scenario itself was not realistic. They did not imagine it would be possible to discuss first sex before it happened. They regarded first sex as unplanned and opportunistic and not something that would be discussed in advance. Boys' groups in particular felt first sex was often unexpected. This reinforces the traditional roles in which boys are usually expected to push for greater sexual intimacy, while girls only have the power of permitting or denying it. Unplanned intercourse is more likely to be unprotected. In addition, most boys did not think that first sex was something to be discussed before it happened as they felt that their friends would not be helpful in this situation:

"I think usually the first time you don't actually plan to do it, it just kind of springs up on you. You don't actually plan, right I'm going to do this then with

whoever. Its more of a personal matter so you don't its hard to speak to anyone about it....At school, you take the piss as much as you could...I wouldn't talk about it in school to a friend".

Brownton/Pinkham Boys 16+

There is a risk attached to revealing personal matters for boys. Revealing themselves to their peers exposes them to potential ridicule. Male friends are seen as likely to use this vulnerability as ammunition against each other. The school environment is here seen as particularly unsupportive for boys. It has been noted that male friendship groups often operate within a narrow frame of conventional heterosexual masculinity, which is regulated by the groups through banter, put-downs and insults[88] [89]. These kinds of exchanges leave little space for discussions of emotions or revealing confidences, and can be very isolating.

Whilst male friends were seen as unlikely to help, boys did think that this was something to talk to their girlfriend about:

"Talk to their partner..Make sure they use protection... a condom."

Greyville Boys 16+

Girls also felt that in the right relationship you should be able to talk to your partner, but sounded ambivalent about this in reality:

"You should be able to talk to your boyfriend, I think... if you're going to have sex, you've got to be very close I think".

Brownton/Pinkham Girls 16+

There is a notable uncertainty here ("you should be able to.... I think"), again recognising the gap between the girls' ideal relationship and real encounters. Not all the groups mentioned the person they were going to have sex with as someone to talk to before the event. This absence reaffirms the difficulty both of talking about sex to partners and of predicting intercourse for these young people.

In two of the boys groups, practical considerations were uppermost in their minds when this situation was discussed, in particular, where a couple could have sex. As most of the participants lived in a parental home, privacy could be a problem:

> *"The other thing would be – where are they going to have it...the first time should be somewhere quite good, so its memorable...I let him have my bed."*
>
> Greenham boys 16+

> *"Try and figure out some place somewhere, and when....you want to make it nice."*
>
> Redton boys 16+

Most teenagers have limited privacy since they live with parents or other carers. This may be one of the reasons why first sex is opportunistic as it is not always possible to have the inclination, the partner and a secluded enough location for sex to take place.

Key Points

- Most teenagers would not consider going to a health professional before having sex for the first time.
- If they spoke to anyone, participants would talk to a friend or their partner before first sex. Boys were less likely than girls to talk to their friends.
- Provided they were sure they wanted to have sex, groups would encourage their friend to do so. Most would advise using condoms.
- Most participants felt that first intercourse happened spontaneously, without planning and so prior discussions would simply not occur.

Scenario 2: wanting to find out more about contraception

This scenario provided opportunity to discuss a number of different health professionals, and their advantages and disadvantages. A number of different places were mentioned, all with negative and positive elements: the doctor, Family Planning Clinic, school or college nurse, youth services, friends, parents and teachers. Most groups mentioned the GP and the FPC, with awareness of other sources varying. Available services varied from location to location and groups also varied in their knowledge of what services

were available, where they were and when they were open. Some groups contained experienced services users whilst others worked by hearsay.
On the whole, boys' groups were not so well informed as girls' groups about the services that were available locally. For example, the Family Planning Clinic was mentioned in several groups but further probing revealed that they did not know where their local clinic was. Boys were also more likely than girls to regard the GP as someone that dealt with strictly medical or clinical issues, and did not see them as someone to discuss issues with.

In the girls' groups, individuals showed different preferences for different providers. Some were happy to go to their GP whilst others found this unacceptable, and preferred the FPC, a youth service or a school nurse. Where services were only available at certain times of the week this was seen as restrictive. For all services, there were concerns about confidentiality, anonymity, and the attitudes of health professionals. Those in more rural areas had problems with getting to and from services, and these were exacerbated when opening times were restricted.

To avoid excessive repetition, quotations about the relative merits of the different providers mentioned in relation to this scenario are described in detail under the theme of "service provider" later in this chapter.

Scenario 3: wanting to get condoms free of charge

The groups were asked where they would tell their friend to get free condoms. Some groups, especially boys, required prompting to think of locations where condoms were available for free. Pay sources mentioned included the chemist, petrol stations, supermarkets and most often vending machines, especially in toilets.

Availability
Aside from some embarrassment to overcome, condoms were generally seen as widely available and easy to get hold of:

> *"You can get them anywhere...I don't think there's an excuse for not having them really".*

"No its not as though they're hard to get."

"I mean it's embarrassing but.."
"No it shouldn't be embarrassing. Nobody thinks anything of it anymore. I mean if you just go up and pay for them in a shop, it's like buying a loaf of bread."

"You're always going to be a bit [embarrassed] though aren't you?"

"I'm always more embarrassed about buying Tampax though really."

Brownton/Pinkham Girls 16+

Retail outlet and machine availability has gone some way to alleviating the embarrassment associated with obtaining condoms, making their acquisition seem normal.

Health Service Provision of condoms

Again, health professionals, including doctors, the FPC, school or college nurses, and young people's services were all mentioned, as well as youth workers. Generally there was good knowledge of the sources available, though these were sometimes location specific. Some participants had experience of using these sources. In a number of cases, an amusing or embarrassing over supply was perceived:

"College. We've had about 50 in the last week haven't we!"

Redton Girls 16+

"You just go to the doctor and they give you a whole bag of them!...So you have a little complimentary stash here until your next time."

Blueham Girls <16

From the Family Planning Clinic..get one of those little candy bags..they give you about 40 though!

Greenham Girls 16+

"I've had hundreds, a great carrier bag full! They're packed in the little paper bags, the ones they put sweets in."

Greyville Girls <16

For teenagers in sexual relationships, the frequency of intercourse may be quite low and receiving large numbers of condoms may seem inappropriate. They also have to find somewhere to store them privately.

Boys were sometimes very creative with solutions for getting free condoms from non-official sources:

" [Condom Machines] are pretty good, the bus station ones, where there's like, there's panels to stop people putting their hands up and someone ripped it off. You can just put your hand up and get them...."

"You can nick them out of your Dad's drawer."

Blueham Boys <16

These comments underline boys' unwillingness to come into contact with health professionals. They mostly preferred to use retail outlets, especially machines that offer privacy and anonymity. Those in public and pub toilets were mentioned frequently. Alternative "free" sources included relatives – brothers or sometimes fathers, friends and their partners.

Key Points

- Groups felt that condoms were readily available.
- Most groups could name a number of different places from where they could obtain condoms.
- Boys were less likely than girls to think of using free condom sources.

Scenario 4: worried about having caught something from having sex

"Say I'm with a girl...and if I do think I'm going to do anything, it's not the first thing, it doesn't come to mind is HIV or anything...it's just getting my leg over."

Greyville boys <16

Groups were asked how they would advise a friend who thought they might have caught something from having sex. The question was phrased vaguely to see how they would interpret this information. It has been shown that while many teenagers know about HIV/AIDS, they have much less information about more common STIs and may still not recognise themselves as potentially at risk. This was also the case in the school-based survey described earlier.

Knowledge of Sexually Transmitted Infections

There was patchy knowledge about different kinds of STI and although most mentioned HIV/AIDS, there was limited awareness of other infections. Girls groups tended to know more than boys groups:

"There's gon-, gon-, gonorrhoea whatever it's called..."

"HIV and AIDS...."

"There's another one that begins with C."

"Chlamydia"

"That's it."

Redton girls 16+

One girls group was aware that young people should be particularly aware of chlamydia but thought that this was because it was very common in her local area.

Where to Go

Few were aware of the GUM clinic, and although some groups thought there might be a special STD clinic, they were unsure where it might be or what it was called.

"There's a G.U.M. clinic....Gen, GU-thingummy. Genital or something ... Universal Masturbators."

Greyville Girls <16

"There is a clinic isn't there for STD users? Isn't there? I'm sure there is."

Redton girls 16+

In all cases, the GP was suggested as the best place to go. Family Planning Clinics were mentioned less often in this context, and generally not seen as an appropriate source of help.

STIs were generally considered to be a serious problem, several groups said that it was important to go as soon as a problem was suspected to prevent the condition worsening:

"Go to the Doctors straight away."

"I'd drag them there by the hair!"

Brownton Girls <16

"If they leave it too long, it will just get worse won't it? So I think you should just go straight away, if you've got something, just get it over and done with. There's no point sitting on it...It's not worth thinking "Oh have I got it or have I not got it?""

Greyville Boys <16

"I think with something as, you know, that's potentially quite serious you've just got to get over whatever embarrassment you've got and just do it."

Brownton/Pinkham Girls 16+

The possibility of an STI was alarming to most groups, and they would be anxious to ensure that their friend sought professional help.

Diagnosis and Treatment

The question was deliberately vague. Probing about how a diagnosis would be made and treated revealed quite a lot of ignorance. All were aware however, of the potential to get something "life threatening" (Brownton/Pinkham Girls 16+) through sexual contact. Most were also unclear about what STIs might cause in the way of symptoms. No one mentioned contact tracing or informing their boyfriend or girlfriend. Only one group mentioned the three-month window prior to HIV testing.

"A urine sample, possibly one of those smear things. Would he do one of those?"

"I don't know you might, a swab."

"Possibly, no, would you, is there a blood sample?"

Redton Girls 16+

"You hear terrible things about people being infertile and you know, infections travelling up to their brain and all that...going blind and legs falling off and all sorts of things."

Brownton/Pinkham Girls 16+

The last speaker is mixing real possible sequalae, with more alarmist predictions.

Treatments included "Some cream" (Greyville boys 16+) or, bizarrely, "Brillo pads from your doctor's" (Brownton/Pinkham Boys 16+). Details were usually sketchy, although this girl seemed to have a fair idea of the range of treatment available:

> *"Creams, injections or it could be a life-threatening disease and you're stuck with it for ever and ever Amen...Or antibiotics, I forgot"*
>
> Redton Girls 16+

There were considerable amounts of half-knowledge or mis-information. One girl had heard of "ginial warts" (Redton girl 16+) and another of "herps" (Greyville girls <16), several confused swabs with smear tests. One girl thought she would be able to diagnose herself:

> *"I think there's a lot of sort of books around that you can read and you can pretty much tell yourself if you've got [an STI]."*
>
> Brownton/Pinkham girl 16+

This was the only example of someone believing they did not need medical help, but no group mentioned the possibility that STIs may be present without symptoms.

Key Points

- Most groups emphasised the need to get medical attention, usually without delay.
- Uniquely among the scenarios, the imperative to be treated was felt to far outweigh any concerns or embarrassment about seeing a health professional.
- The GP was most often suggested as the appropriate person to deal with an STI.
- Very few participants were aware of GUM clinics.
- Most participants were ill informed about STIs – names, diagnosis, symptoms or treatment.

Scenario 5: the condom broke

This scenario, where a condom had broken during sex, was intended to elicit knowledge of emergency contraception (EC), its time limits and availability.

Knowledge of EC

Almost all of the groups displayed some knowledge of the possible need for EC in the case of a broken condom. However, as with all the groups, assessing the level and distribution of "knowledge" of a contraceptive method in the groups is difficult. In FGDs one or two individuals can give the appropriate cues which are then picked up by others. The group discussions tended to back up other quantitative work such as the school-based survey which suggested that boys tend to be less well informed than girls about EC.

In only one group was it clear that they did not understand what was meant by EC.

> ***Mod**: "Do you think it would be easy to get an appointment for [Emergency Contraception]?"*
>
> *"No, shoot down to the pub don't you and get it.. put a quid in the machine and get one out."*
>
> *"That's what I call an emergency, its a condom innit if you're gagging for it, it is an emergency!"*

Greyville Boys <16

Another group of younger girls didn't mention EC without prompting, and initially suggested a pregnancy test, or waiting to see if their period started (Blueham girls <16). And in a group of younger boys there was uncertainty about what EC was for:

"[EC] stops the girl from having a baby"

"Does it stop the girl from having a baby?"

Blueham boys <16

Several groups did show considerable dependency on the experience of only a few group members, after whose comments those who may have had uncertainties would likely have had them cleared up.

Although some had heard of an emergency IUD, this idea was not well regarded:

"You can get an IUD as well, up to five days afterwards.. but they're a bit scary...they stick a wire up."

Greenham Girls 16+

"You can have the coil...its well weird. you have it, you know, and shove it up you. My mum has that and it all rotted."

Greyville Girls <16

Many individuals were wary of the IUD, and found the idea of it unpleasant. However, the IUD is rarely used with teenagers.

Time limits

Although most knew that hormonal EC can be used up to 72 hours after sex, some groups weren't sure.

"Haven't got a clue."

"48 hours isn't it?..."

"24 hours."

"I think 48 hours."

Greyville Boys <16

***Mod**: "And did you know the details? The times?"*

"I just thought what it was said to be, morning after pill."

"Didn't know it was up to 72 hours."

" Never used one!"

***Mod**: "What about the others of you? "*
"Yeah, I know of it, but I don't know great details."

Greenham Boys 16+

Where to go for EC

Although in most groups at least some of the members had a clear idea of where to go for EC, the following show that this knowledge is not universal and that some are not clear that EC is a drug which must be prescribed.

" She got hers from the hospital, she didn't know where else to go."

"Doctors."

" That's the only place I'd have thought of – doctors or family planning, I don't know about the hospital and that."

"I didn't think about the Hospital, like."

"Nor did I 'til you said that."

Redton Boys 16+

Mod: *"Where do you think you can get [EC] from?"*
"Family planning centre."

"Again, the family planning thing, yeah, and the doctor as well. 'Cos she went to the doctor..."

" So it's not prescribed. It's a drug then, is it? "

"Family planning clinics, they have the power to prescribe then do they?"

Greenham Boys 16+

In both these boys' groups, some knowledge has been gleaned form friends or girlfriends who have used EC. Most groups mentioned GPs and FPCs as a source, some mentioned A&E departments and, in a few cases the school nurse.
Knowing that EC is available from FPCs or from youth services is only useful if the location and opening times are also known. In the case of FPCs a general lack of knowledge of location and times is shown both in these FGDs and the student survey

Concern about side effects
While some could identify the fact that there are side effects when using EC, they could not put them in perspective and recognise that serious side-effects are experienced only by a minority of users.

"It make you really sick. You take the first one and you think you're all right and you are [vomiting noises]."

Redton Girls 16+

"Didn't know it made you puke."

Greenham Boys 16+

"I had a friend who took it and she puked everywhere. She said it's horrible, it makes you sick."

Greenham Boys 16+

Misinformation about EC

There was considerable misinformation about EC. Some groups emphasised the immediate negative effects of EC, in some cases reflecting lack of knowledge about how EC works.

> *"The morning after pill, right, it makes, it right mucks up your period, like you either come on 2 weeks early or two weeks late or not at all."*
>
> Greyville girls <16

> *"It flushes you out."*

> *"Cleans it out..."*

> *"Hormones are released and the girl has a period."*
>
> Blueham Boys <16

The speakers in the second quote are unclear about how EC works or what it does to a woman, but the affects sound quite dramatic the way they choose to describe them.

Other groups were concerned about the long-term effects of EC:

> *"There's only so many times you can use it before you sort of, you increase your risk of having ectopic pregnancies and things."*

> *"You're meant to only use it three times aren't you? Cos it can really mess up your liver and kidneys and loads of things...and whether you conceive later in life, and lots of things."*

> *"It's pretty strong stuff, innit?"*
>
> Pinkham/Brownton Girls 16+

The school-based survey supports this lack of knowledge of the safety of EC. Between 60 and 70 percent of boys and girls in Years 9 and 11 responded that they did not know if it was safe to use EC more than 3 times a year. Such fears about the potential damage resulting from EC use may make young women uneasy about using it.

Effectiveness of EC

The effectiveness of EC especially in relation to other forms of contraception was not discussed in most groups and when one group was directly asked about effectiveness the response was less than certain.

> ***Mod**: "Do you think it is effective?"*
>
> *"Yeah. Its meant to be."*
>
> *" It makes them ill, I know that."*
>
> Redton Boys 16+

Limiting Availability

All of the groups had reservations about EC and it was regarded as a dangerous, high-powered drug by most. This tended to make participants cautious about using it too many times, and in making access too easy in case others were tempted to take it too many times.

> *"If you make it too easy, I think people will just start using it"*
>
> *"And it's dangerous cos its quite a strong medication isn't it?"*
>
> Pinkham/Brownton Girls 16+

Barriers to access for EC

In view of the time limits in play, quick access is important for EC. When trying to see the GP, receptionists were seen as one important barrier to easy and urgent access to EC:

> *"The receptionist's like "Well, why do you want to see the doctor straight away?"...The receptionist was really funny with me. In the end I had to tell her why I wanted to see the doctor like, ASAP. And she was really funny with me, so I mean, I don't know whether I'd go back to that same doctor's surgery to get it."*
>
> Pinkham/Brownton Girls 16+

> *"I mean I think they have a right to know ... I think they need to know why you your getting an emergency appointment, but I think it's just the way they deal with it."*

> *"Especially when you're stood at the front of the desk and they say "Why do you want an emergency appointment?"*
>
> Pinkham/Brownton Girls 16+

Perceived barriers to sexual and reproductive health services, including access to EC, are discussed in further detail under this theme later. These include trust of service provider, geographic accessibility, and perceived appropriateness of the service for teenagers. Young people clearly feel discomfort especially in approaching their GP. The FPCs are seen as providing a more user-friendly service but for many young people in rural areas urgent access, as is needed for EC, is not always easy or possible.

Jokes, Jibes and Responsibility

Some responses included a few jokes and jibes before they moved on to discuss EC:

> *"I'd just say "Bad luck mate!"."*
>
> Pinkham/Brownton boys 16+

> *"I'd say "You stupid girl!"*
>
> Brownton Girls <16

For some, these jibes can be seen as a denial of responsibility:

"Shit yourself!"
[Laughter]
"It's time to move on boy! ..."

"Trinidad or somewhere sunny!"

"I suppose, you'd have to contact, contact the um bit of stuff you were having sex with and um tell them...the situation, and tell her she should go to the doctor..."

Greenham Boys 16+

In at least one case it was argued in the group that both partners should go to the doctor if EC was needed:

"So you basically get her to go to the doctor and . . ."

"Both go to the doctor."

"Yeah."

- Redton Boys 16>

Key Points

- Most groups contained participants who were aware of EC, although knowledge about how it works, where to obtain it and time limits was variable.
- There was considerable apprehension about using EC, with both immediate and long-term side effects exaggerated.
- Receptionists were identified as a barrier to getting quick appointments at the GP.
- Other services, such as TAC or weekly FPCs, may operate too infrequently to be useful for EC.

Scenario 6: a friend had an unplanned pregnancy

The final scenario asked what advice they would give to a friend who thought she might be pregnant, or whose girlfriend thought she might be pregnant. This scenario created a lot of discussion. Most groups emphasised the importance of confirming that the girl was actually pregnant – this could be at a GP or FPC, or in many cases, through a home test from the chemist. Most groups saw pregnancy as a teenager very negatively. The exceptions were both found in the older Redton groups. In the over 16 girls' group, one of the participants was pregnant and this coloured the response of some participants. In the over 16 boys' group, one participant expressed himself keen to become a father.

Stigma and Teenage Pregnancy

Most other groups expressed judgmental comments about teenage mothers. The following exchange concerned a girl known to the group from their year in school who had recently had a baby:

> *"She's not doing her exams or anything., Its a waste of her life...They've got no money, they're living off all the other people's taxes and stuff like that, living in a flat paid for them with a kid. What kind of a life is she going to have?"*
>
> *"She was drinking and smoking when she was pregnant."*
>
> *"I don't think girls like her should be allowed to keep the baby."*
>
> Greyville Boys <16

This young mother was condemned for living on benefits as well as for dropping out of school and not behaving responsibly during her pregnancy. It is interesting that this same group had strong moral objections to abortion, and yet also wants to police those choosing motherhood!

Parental Involvement

Unplanned pregnancy was the one area where most groups said that they would suggest talking to parents, especially their mother. Most regarded this with trepidation. Opinions were divided when speculating on how helpful or supportive parents would be. Most expected them to be upset, disappointed or angry. Fathers in particular were generally

considered more likely to be roused to anger by an unplanned pregnancy, especially if the girl was very young:

"If it was a bit lower down the school I can see that like, maybe not her mum going off her head so much, but her Dad, I know my Dad would have."

"I can't imagine my mum would be that keen either."

"They'd go "Aaaargh!"

Greyville Girls 16+

"So many people react in different ways. I mean, my Mum and Dad always said "If you get pregnant, you're out on the street" and I mean when it comes down to it, if I did get pregnant they probably wouldn't throw me out on the street. But they might. You never know."

Brownton/Pinkham girls 16+

"Dads get angry more. They're more over-protective."

Brownton Girls <16

"My parents would help me out I reckon. After I'd got a whupping!"

Greyville Boys <16

- ***Mod**: "What would your parents say?"*
"You've ruined your life."

The concerns about parental reaction may be real or imagined but expectations of criticism were almost universal. It is clear that these groups feared approaching a parent about such a situation. One girl described a relation faced with a teenage pregnancy who had been persuaded by her mother to have an abortion when she had planned to keep the baby:

"The deal was between her Mum and her was that she could stay with her boyfriend who had made her pregnant...that was the deal so she'd have an abortion...So her mum had to bribe her to have an abortion."

Blueham Girls <16

Such stories may accentuate fears that these teenagers had about parental reaction.
In one group the boys felt that their father would ensure that they took responsibility for what had happened:

> *"He'd make me stick by my girlfriend no matter whatever happened afterwards. So if I didn't want to know like 'cos she'd had a baby, my dad would make me support her and stuff, I know that."*
>
> Redton boys 16+

Apparently prepared to "do the right thing", this speaker describes the situation as his girlfriend having "a" baby, rather than it being "his" baby, thereby distancing himself from the situation.

Coping Alone

Pregnancy was a serious matter for almost all the groups. Anxiety about how people would react, and insecurity about what kind of support might be offered was common. These fears about their parent's reaction led to some groups preferring to try and deal with the situation on their own without involving their parents.

> *"You've got to try and sort it out first. [Telling your mum is] sort of like a last resort."*
>
> Brownton/Pinkham boys 16+

Another boy was keen to try and "sort it out", (which indicated arranging an abortion) without parental involvement. He seemed to mistakenly regard use of EC as ending a pregnancy in the same way as abortion:

> *"If I got someone pregnant I'd see if I could sort it out myself first and that, but if I couldn't I'd go to my parents for advice."*

***Mod**: "What do you mean by you'd try and sort it out?"*

"Like go and get the morning after pill or something like that, see if you can arrange some other things like terminate the baby or whatever."

Greyville Boys 15-16

Trying to cope with an unplanned pregnancy on their own would be both stressful, and as one group recognised, could waste time when it was important to act quickly if someone wanted an abortion. It was recognised as important to confirm the girl's pregnancy and to decide what to do in a short period of time:

"You've got to be quick about these things because..you've got to decide what to do. And if you don't realise you're pregnant until you're two months gone then its a pretty fast process...as it goes on your range of options get smaller and smaller. It goes so quickly."

Brownton/Pinkham Girls 16+

Although many groups feared the worst from their parents' reaction, this may not materialise in the event. One group described how a friend's fear of his mother's reaction had prevented him from telling her that his girlfriend was pregnant until after she had undergone an abortion:

"And his mum was totally supportive of him. And he was so scared of telling his mum he didn't tell her for ages."

Redton boys 16+

Partner Involvement

Most groups felt that it was important to discuss things with a partner. However, several of the girls groups also recognised that a pregnancy may not occur within a supportive relationship, and that there could be tension between what the partners wanted to do.

"Talk about it with your boyfriend."

"If you had one!"

"They might just tell you to bugger off."

Brownton/Pinkham Girls 16+

"It depends how close she is with her boyfriend..."

" Or what kind of boyfriend!"

"...if it was a one night stand then, but if its serious, then you should discuss it with your boyfriend."

Greenham Girls 16+

These girls are aware that they may be left "holding the baby" and were ambivalent about involving a casual partner in discussions about what to do about an unplanned pregnancy.

Attitudes to abortion

Despite the pregnancy being described as "unplanned" in the scenario, a number of participants did not regard abortion as an option. Both boys and girls in some groups discussed it very negatively. Many saw abortion as morally wrong, and some girls felt they could not have an abortion themselves:

"I could never have an abortion."

"Neither could I. I think it's wrong."

"You shouldn't bring something into the world if your not going to give it a life."

Greyville Girls <16

"If she didn't want it, I don't think killing it, I think someone else is looking for a baby, so might as well let them adopt it...Stuff like that, killing it, it's cruel. I hate it, that's horrible."

Greyville Boys <16

These strongly held opinions limit these respondents options and for them a pregnancy, unplanned or not, would result in a baby. This scenario was discussed in terms of how they would cope in this situation. Some felt that if they couldn't cope with a child, adoption would be an option, albeit a difficult one. This perhaps was seen as a humane solution to the recognised difficulty of having a baby at a young age, but this is also a difficult option:

> *"I think people kind of think there's two options, like abortion or keeping it, I don't think many people think about adoption..."*
>
> *"That would be awful..having it and then saying goodbye."*
>
> Greenham Girls 16+

Few groups recognised that adoption would be problematic, and it was often regarded with (perhaps) unrealistic optimism.

Decision Making

In one group, where one of the participants was pregnant and planning to have her baby, their reaction to a friend's pregnancy was initially very different:

> *"Put your arm round her and say "Brilliant mate! What would you like me to buy it then I'll be Godmother!""*
>
> Redton Girls 16+

There is an assumption here that pregnancy will result in birth. The reaction very much coloured by their experience of having a pregnant friend. This same girl however, had very clear views about her own inability to be a teenage mother:

"If I ever fell pregnant, then it's time to sit down with the father, the family, and you've got to really talk things over, yeah I'm 16, I'm too young, I'm still a child myself. I want a career and I do want a family but maybe another ten years on from now."

Redton Girls 16+

This theme of maturity and readiness for parenthood as a role was repeated in several groups. Many felt that they were too young for parenthood:

"You may be physically mature but not mentally you're not.. We've still got a hell of a lot of growing up to do before you think about kids."

Redton girls 16+

In these cases, the participants were more likely to think that abortion was an acceptable choice.

In some groups, discussions of what it might be like to have a baby as a teenager included rather unrealistically high perceptions of the level of support available, both from family and within educational and employment environments. Such expectations made them more likely to think that they would cope with a baby:

"I'd give it to my mum."

Greyville Boys <16

"Loads of people get a career and loads of people are having kids now...There's businesses with crèches... you go to see your kids loads of times in the day but you still do your work"

Redton Girls 16+

None of the groups suggested going to a counsellor to help them decide what to do, nor did they think of talking over their options with a health professional, whose role was considered to be limited to undertaking a pregnancy test. In all cases, the problem of a teenage pregnancy would involve friends, partners or family.

Avoidance Tactics

The question also elicited some joke responses, especially from boys, perhaps indicative of the difficulty of this subject for some teenagers. Initial reactions were about avoiding of responsibility and hiding the truth form family:

"What would you do David?"

"Shoot myself or run!"

Greyville boys 15-16

"I could never tell my Mum and Dad. I'd run away....Eight months three weeks, right, got to go to Australia!"

Greyville Girls <16

"I'd move to a different country!..."

" Move out. Live in the shed."

Brownton/Pinkham Boys 16+

Again, these responses show a high level of fear among teenagers about finding themselves, or a partner pregnant.

More disturbingly, the following comment was made by a boy in relation to abortion:

"Find some dodgy geezer and give him fifty quid."

Brownton/Pinkham Boys 16+

Joking as it is, it is unclear whether or not the speaker genuinely believes that there is still a need or a place for back street abortion, when they are in fact available free on the NHS.

Key Points

- All groups regarded teenage pregnancy as a very serious issue.
- Most thought that parents should be involved but were scared of the reaction this would invoke.
- Fear of their parents would lead some participants to try and cope without their help.
- Most girls were sceptical about the amount of support they would receive from a partner.
- A number of the teenagers had very negative views about abortion, and overly optimistic views of the help available with childcare.
- If they felt they were too young for parenthood, they were more likely to accept abortion as a reasonable choice.

Thematic analysis

The FGDs produced an enormous volume of qualitative data. Material that seemed most easily discussed under the various scenario headings has been presented above. Much of the data however was classified under key "themes" as has already been described. This data is presented below:

Theme 1: perceptions of service providers

The scenarios described above provided the opportunity for FGD participants to identify services that they knew about in their local area. In some cases, a fuller discussion of why services were felt to be suitable or unsuitable emerged at this point. For others, the moderator returned to any source of assistance mentioned once the scenarios had been discussed. There is a considerable literature about how to provide youth focussed sexual health services. Some was referred to in the introduction (including Isobel Allen's work quoted below). Services for young people need to be friendly, accessible and confidential. Getting these aspects right is key to the success of services:

One of the great challenges for service providers and those working with young people is to design services which meet young people's needs and are attractive enough for them to use them regularly and consistently (Allen, 1991)

In most of the groups there was no one preferred provider for contraceptive and other sexual health services. Individual members of the groups preferred to use an FPC, others a GP and others a school or college nurse. Several studies have suggested that where they are available, teenage girls would rather attend a FPC than their GP[90] whilst boys would rather use vending machines for their condoms. Themes of the benefits and barriers to using particular providers did, however, recur in the groups. Discussion relating to the use of the GP, FPC, school or college nurses and specialist teenage services follows.

General Practitioner

All groups knew that their GP could provide sexual health services and the doctor was mentioned as a source of at least some of the services required in the presented scenarios.

For some, this was their preferred source of contraception and advice. Some felt that the GP was more convenient than other sources of advice and services as it was closer to them, and open all week. In most groups, the GP became a progressively more important figure as the scenarios presented progressed in "seriousness". Thus, whilst few thought it necessary to see a GP before embarking on a sexual relationship, all groups thought a GP was the most appropriate person to see if someone suspected they had an STI.

General Practitioners now provide three-quarters of the contraceptive care given to women in the UK. For those in more rural locations, the GP may be the only local service provider to whom they can go for sexual health advice. In a study of 167 pregnant teenagers in North and East Devon,[71] twice as many had seen a doctor for contraception as had used a FPC. The study also highlighted problems of service access for teenagers – this may be lessened by using a local General Practice, compared to FPCs, which may have more restricted opening hours (and which are only available in some locations). However, the school-based survey undertaken for this project showed that a fifth of questioned teenagers lived more than five miles from their doctor's surgery, making physical access an issue here too. Whilst most teenagers in the Pearson study[71] who had seen a health professional were happy with the service they received (whether from a GP or an FPC) a number of concerns were also voiced. These included fears about lack of confidentiality, perceived lack of helpfulness of the GP and embarrassment. Some also felt that their consultation lacked privacy.

Doctors' Knowledge and Professionalism

On the whole there were positive feelings among groups' participants towards the doctor. In particular, participants felt reassured that they would be given appropriate care because GPs are expected to be familiar with their patients' backgrounds. Their medical training was also respected, and they were expected to be professional and informative.

> *"They do know your medical background so they know all the things."*

> *"And they're professional as well, so you'd feel that you weren't going to be judged or whatever."*

"And its definitely confidential, cos otherwise they can get into big trouble."

"It's a bit reassuring as well to go to a doctor."

Brownton/Pinkham Girls 16+

These girls particularly value professional competence in their doctor. Training, professionalism, impartiality and trustworthiness all affect their perception of this service. Confirmation of a doctor's training and experience has been shown to positively influence teenagers' willingness to use a particular doctor[91]. The General Practice was also seen by some as being more convenient than other sources of advice and services. However in a few cases, participants expressed a lack of trust in their doctor's abilities:

"My little cousin Jane, she had like a rash and everything and the next minute she had meningitis and they said it was just 'flu. She could have died."

Greyville Girls <16

"He doesn't know his arse from his elbow. He just hasn't got a very good track record...Things he's said and stuff he's prescribed and stuff are not good."

Greyville Boys 16+

It is hard to know whether these are real or enhanced scenarios but their effect is to lessen the respect that young people have for their doctor.

Judgmental Attitudes

By contrast, a few of the groups felt that doctors in general were not in touch with young people, and feared being judged by them:

"I think they don't like to think that people like our age and younger are actually having sex. I think that's the whole problem really with the doctor."

Greyville girls 16+

Concerned that the doctors would disapprove of her, this speaker explicitly preferred a specialist service where she felt the staff were more familiar with her age group and accepting of their behaviour.

Confidentiality

Confidentiality is often mentioned as the single most important aspect of young people's services. Doctors' duty of confidentiality to their patients was, on the whole, well known and trusted – and in some cases this was prime reason for choosing to use that service:

> *"They can't, they're not allowed to tell your parents anyway, anything are they? You go to them in confidence."*
>
> Blueham Boys <16

Confidentiality is here understood as the *basis* of the doctor's services. This was not the case in all groups however, and there was some evidence that teenagers did not believe that their visits would remain confidential, or did not fully understand what confidentiality meant. There was uncertainty in several groups, and not all were confident in their doctors:

> *"He treats my whole family as well so I'd probably feel uncomfortable about it. I don't know if its confidential enough."*
>
> Blueham boys <16

> ***Mod:*** *"Do you worry that the doctor might break confidentiality?"*
> *"Yeah."*
>
> *"No"*
>
> *"Depends what doctor."*
>
> Greenham girls <16

It is vital that young people are reassured of confidentiality when seeing their doctor. It may need to be explicitly stated that this is the case even if their doctor also treats other members of the family.

Threats to Confidentiality

In small communities, the local doctors may be well known figures. Some groups thought that because their doctor knew their parents outside a professional context, a consultation would not stay secret in social situations:

> *"My doctor is sort of like my Dad's best mate and I'd be embarrassed like just say one night ..it slipped out."*
>
> Greyville Girls <16

> *"My doctor is really good friends with my mum...and its a bit, just talking about you having sex and that with the doctor's a bit, is it going to come up at any time with my Mum? And I know it won't its just always at the back of your mind I think."*
>
> Greyville Girls 16+

> *"I see him through my parents socially and I would find it really awkward"*
>
> Greenham girls 16+

There is a lack of trust or understanding that a professional obligation to confidentiality is binding, even or particularly in social situations. Teenagers may need to be given a better understanding of the nature of confidentiality as this distrust may prevent them from using their GP for sexual health matters.

Other participants were concerned that their parents would find out about a visit at subsequent non-sexual consultations when their parents accompanied them. Many young people continue to attend doctors appointments with a parent, indeed, in the school based survey a third of Year 11 and half of Year 9 pupils had never attended a doctors' appointment on their own. Some participants had direct experience of doctors who had not realised that some of the information may not be appropriate to reveal at all consultations:

> *"[Mum] came in and they took me into the examination room and he said "Oh do you take any regular medication?" And my mum was sat there, and she didn't know so I said "No" And he goes "Are you on the pill?" and I'm like "Shhhh!"*

Greenham Girls 16+

This girl reported that she subsequently returned to her doctor alone to check that the medication she had been prescribed would not interfere with the pill she was taking from the FPC.

Other groups were concerned about the use of computer records, and thought that it was too easy for others to see what appeared on the screen if it wasn't turned away from the patient:

> *"They've got this screen, its got all your records on it, you can see all the records. If your mum's sitting there she can see all the records."*
>
> Greenham Girls 16+

In other groups, participants were unsure whether of not their parents might have access to their notes. Anything that was written down was therefore considered as a threat to confidentiality.

> *"Even if you just go and like ask about something it is still put down on record so parents can find out about it."*
>
> Greenham Girls <16

This group followed this notion up by suggesting that a suitable doctor for teenagers was one that "Doesn't put unnecessary things in your notes."

Anonymity

For many of the groups, it was not so much issues of confidentiality that concerned them as those to do with anonymity. This was at the forefront of many groups' anxieties about the doctor. Living in rural areas and small communities, the doctor's surgery was felt to be a very public space. Teenagers anyway feel very visible in such communities where their activities may be under scrutiny from adult residents[92]. Some speakers valued the GP because a visit to the doctors does not automatically expose a need for sexual health services, unlike a visit to a FPC:

> *"If someone sees you going to the doctor then it wouldn't necessarily be like a sexual reason would it?"*

Greenham girls 16+

This was not reassuring to most participants however. There were a lot of concerns that they would be seen at the doctors or in the waiting room and that their parents would be told or find out through the town "grapevine." Their parents' suspicions would therefore be aroused. These fears extended to participants own friends, friends of the family and relations as well as non-medical staff who worked at the doctor's or in the chemist:

> *"The problem is you go in there and you'll see loads of your friends in there and you'll think oh God, it's going to go all round the village, my mum's going to find out."*
>
> Brownton Girls <16

> *"Everybody knows, well not everybody, but lots of people know people that work there."*
>
> Greenham Girls <16

For some, especially those under sixteen, fear of the spread of information through these informal networks overrode their knowledge that actual consultations are confidential. Gossip takes on an almost mythical power in their descriptions – as one girls put it "It's just like, in the air" (Greyville <16):

> *"I know its completely confidential but like if you are under 16 then your parents will find out even if you just go."*
>
> Greenham Girls <16

> *"It might be the doctors are not allowed to say anything but you go in there and the next day its all round Greyville!"*
>
> Greyville girls <16

All the groups from smaller communities (all those other than Redton) were acutely aware that privacy and secrets were difficult in their hometown. This was a seriously inhibiting factor.

Limited Role of the Doctor

The doctor was not always considered to be an appropriate source of advice or information about sex or relationships. This was revealed in the scenarios about having sex for the first time, or even finding out more about contraception. These would primarily require discussion rather than a specific need for a prescription. It was widely considered that the doctor was the place for technical or medical matters but not somewhere to discuss issues:

> *"[Having sex for the first time is] not the sort of thing you go to you doctor and talk about, is it?"*
>
> Brownton/Pinkham Girls 16+

> *""I wouldn't be able to talk to my doctor."*
>
> Greenham Girls <16

> *"I see the doctor as someone to give you antibiotics or when you've got a cold."*
>
> Greyville Girls 16+

> *"If you go to the doctors' its going to be all medical background, this is going to do this to you, this is going to do that to you, short term effect, long term effect, that sort of thing."*
>
> Brownton/Pinkham Girls 16+

> *"Doctors are seen as places just for injuries and illnesses, not to go and speak to and that sort of thing....No-one's ever said to me "I went to speak to my doctor"."*
>
> Greyville Boys 16+

These quotes clearly show the narrow focus that many young people ascribe to the doctor's role; one that does not extend to providing information or advice.

In addition, some saw the doctor as a place to go only for a particularly serious medical problem:

"I'll just see him if I've got a really bad injury from playing football or something like that, so I don't go unless I really need to."

Greyville Boys <16

"[I'd go] if I was that worried yeah. Going green I'd start to worry!"

Brownton/Pinkham Boys 16+

These views were particularly those of the boys, who generally saw no reason to seek professional help from anyone, unless the situation was considered strictly medical, such as an STI or serious enough to be out of their hands, such as an unplanned pregnancy. However, whilst girls are more used to the idea that you can go to the doctor when you are not strictly ill, for example to obtain contraception, some still felt that this reason was not a wholly legitimate one for visiting the doctor:

"If its an emergency appointment then its really difficult cos you have to give a reason and they make you feel guilty, don't they in a way? You haven't got a cold or you don't sound ill "What do you think you're having a doctor's appointment for?"

Brownton/Pinkham Girls 16+

There is a clear sense here that this girl has to justify her need for a doctors' appointment and this struggle to be seen can be another barrier to service use.

Appointments

Appointments were often seen as awkward to arrange. In the case of EC, the issue of quick appointments is a strong consideration and trying to get past a doctor's receptionist was often seen as difficult. Some participants recounted their own experience of this:

"When you ask for an emergency appointment, they ask you what its for...I've been in the phone box at school before and I made my appointment and I was going (whisper) "Morning After Pill" she's going "Speak up I can't hear you." (speaks) "Morning After Pill" "Pardon?" (shouts) "Morning After Pill"! I thought "Oh my God everyone's looking at me!" She was horrible."

Greyville Girls 16+

Locally, guidelines were issued to all reception staff about dealing with teenage girls seeking emergency appointments following a North and East Devon EC Audit in 1997. These advised that any teenage girl seeking an immediate appointment should be treated as needing EC unless they state otherwise. It does not appear, however, that these are always followed.

Appointments were also seen as difficult when wanting to see a particular GP:

> *"It's hard to get and appointment with him...I had earache and I wanted to go and see the doctor and I couldn't like see him until three weeks later."*
>
> Greyville Girls <16

As will be discussed below, the personality of a particular doctor is very important for teenagers, so the ability not just to get an appointment, but to be able to see a particular doctor may be a key consideration.

Personality of the Doctor

Many participants had strong views about the personality of their own doctor, and this could affect their willingness to consult them for personal issues. Not knowing who might be available can be unsettling. Several groups mentioned the difficulty of seeing their own doctor:

> *"I don't know who [my doctor] is. He comes and goes, and its always different people...sometimes its a woman and sometimes its a man. It always changes."*
>
> Blueham Boys <16

Ginsburg et al[93] found that the personal characteristics of the health professional were the most important factor in influencing adolescents' decisions to seek health care. This was more important than where the service was or how it functioned. This was borne out by comments suggesting that the preference for (or decision against) the doctor was due to personal relationships and individual characters.

Within any one group, a range of opinions on individual doctors were offered:

> *"If you get on with your doctor it might be easy to approach her/him whichever but I mean if you don't get on with them then its really hard to approach that sort of thing."*

Brownton/Pinkham Girls 16+

"I found that doctors are less judgmental, more comfortable when you ask for the pill...they just like talk to you and they don't appear too judgmental."

"I don't like my doctor anyway so I wouldn't go."

Greyville Girls 16+

"I [felt comfortable] with my former GP but not this one. I'm very uncomfortable with him. Feels like I'm a moaning old git."

Redton girls 16+

"He's always got this bored expression on his face...like you're boring."

Blueham Boys <16

"He's pretty cool. Yeah, I think he'd listen."

Blueham Boys <16

"There's a really nice lady doctor, I really like her...I sort of feel relaxed I can talk to her...You don't feel intimidated...she's just really understanding...she chats."

Greenham Girls 16+

All these quotes relate to the positive or negative characteristics of individual doctors with whom the speakers are familiar.

Gender

The doctor's gender was an issue for both boys and girls. Many girls would rather see a female GP about sexual health issues, but for a number of boys also seeing a woman would be difficult:

"I don't like seeing my male GP you know?"

"Mine's OK I've got two females"

Redton Girls 16+

"I'd laugh if it was a woman and then I'd look like an utter retard."

Blueham Boys <16

Again, it can be hard to accommodate the preference for a doctor of a particular sex if it is difficult to get a quick appointment with a named doctor.

Familiarity with the Doctor

According to a number of the participants, many family doctors had known their patients since they were children and may also treat the rest of their family. This was seen as a mixed blessing. Some participants found this reassuring and were positive about an established level of trust and familiarity. Others felt familiarity heightened their sense of embarrassment, and seemed unwilling to make the transition from seeing their doctor for childhood illnesses to approaching as an adult with a sex life:

"Cos some people have had the same doctor all their life and they've been going since they were three for earache."

***Mod**: "Does that make it easier or harder?"*

"Harder probably."

"I reckon easier cos you know them more."

Brownton/Pinkham Boys 16+

"I've had my doctor all my life and that and I've been seeing him once every month so I've got to know him so, well not every month, I'd feel more safe with him."

Greyville Boys <16

"I couldn't go to the family doctor. I couldn't go there."

Greenham Girls 16+

The range of reaction to seeing the family doctor suggests that there is a need for an alternative source of sexual health care for these teenagers since not all are going to be able to overcome their ambivalence about seeing the GP for such needs. It may be that some of these fears could be allayed if teenagers were made aware that they could make an appointment with a different doctor, or even sign on at an alternative General Practice for contraceptive services only.

Ability to See a Different Doctor

For extra privacy and anonymity and for particularly sensitive issues, such as an STD, or an abortion, some groups suggested that they would like to see a different doctor. They were not aware that they could sign up for contraceptive services with any doctor. For some a stranger was thought easier to talk to than a familiar, family doctor:

> *"I think also people should be allowed to go to different doctor's surgeries for a while because sometimes I find it more easy to sometimes talk to a stranger because I know it would never get back to my parents or something."*
>
> Brownton Girls <16

> *"They may not feel happy to know that if they have an abortion that their doctor's going to know that they've been pregnant and ended that pregnancy".*
>
> Greyville Girls 16+

A termination or acquisition or an STD is a very private thing for many people, and these teenagers were concerned that their continued relationship with their doctor might be coloured by a doctors' knowledge of such events in their lives.

Key points

- In many cases GPs were trusted and respected by the participants and for some people the doctor was their preferred source of information and services for sexual health. A number of potential problems were also identified.
- Most, but not all participants were confident that consultations would be kept confidential. Specifically, they expressed concerns about future consultations that they might attend with their parents, and also that doctors may reveal information to their personal acquaintances.

- Problems of anonymity in small communities were acute – most participants were concerned about being seen and resultant gossip.
- The personality of individual doctors strongly influences teenagers' willingness to see them.
- Teenagers may also be uncomfortable seeing a doctor attended by their whole family, or one who they had seen since childhood.
- There were some participants who simply did not want to see their doctor for any personal matters and ascribed them with a narrow, strictly clinical role. Others felt this was inappropriate when dealing with particularly sensitive issues such as STIs or unplanned pregnancy.
- The gender of their doctor was important for many, both boys and girls.

Family planning clinics

Participants' access to Family Planning Clinics (FPCs) varies widely by location and this influenced their opinions of them. Redton has the only daily FPC in the district. Greyville has a weekly drop-in service at the hospital, which is staffed by a nurse who also works at the local TAC. There is also a weekly community based young people's drop-in. Blueham has two sessions a week at a health centre – one for appointments and one a drop-in aimed at teenagers (this also has staff who run the local TAC). For those from Pinkham and Brownton, there is a weekly clinic at a local market town where the Sixth Form College is located, or the Redton clinic, both of which can be reached by bus. Those living in Greenham area are a bus ride away from Redton.

Most groups mentioned the FPC as a source of free condoms, contraception, EC and for advice about an unplanned pregnancy. Few, however, mentioned it as an appropriate place to obtain advice about an STD.

Attitude at the FPC

Most of the groups mentioned the FPC as somewhere where sexual health services could be obtained. On the whole, FPCs were seen as confidential and professional sources of advice, whilst at the same time being approachable. For some it was important that the FPC was separate form the family doctor:

"Its totally confidential and nothing will get back to your doctor or your parents."

Redton Girls 16+

"Its a bit scary on the outside until you get in there and its really relaxed and I think they're really nice."

Greenham Girls 16+

The fact that FPCs specialised in sexual health, rather than general medical needs was also seen as an advantage:

"They're not there to do anything else but family planing and they can give you good advice."

"They don't judge you……"

"That's the only place you could expect them to be used to it and be able to handle it properly."

Greyville Girls 16+

"They've got loads of leaflets and everything about virtually everything haven't they...you can pick them up while you're waiting."

Greenham girls 16+

In particular, they were felt to be relaxed and well informed about sexual issues and familiar with the kinds of problems that teenagers may need to consult them about. Several groups who had used the FPC mentioned the positive attitude of staff:

"I think [the nurses] are really nice sunny people anyway and it's better if you go into the atmosphere relaxed, I think."

Greyville girls 16+

"They're brilliant, and like they'll talk over your options and stuff."

Redton girls 16+

Being able to talk problems over, and feeling relaxed in the FPC setting were highly valued. However there were also a few negative comments about staff at FPCs:

> *"They don't push you, well one of them does...I found up at family planning they were quite insensitive."*
>
> Redton girls 16+

> *"I don't like it when they talk down to you."*
>
> Greyville girls 16+

As with the doctor, FPC staff were criticised if they were felt to be critical or not attuned to teenagers. These experiences were the minority when discussing FPC staff however.

Anonymity

Although many participants valued the fact that an FPC offered specialist advice, this also means that it is obvious that those going into the building are there for something relating to sex. As with the GP, there is still the problem of high visibility in small communities. Attendance at an FPC is a covert admission of sexual activity and this is both potentially embarrassing and less anonymous than a General Practice:

> *"I think why I wouldn't go there because everyone knows that that time is Family Planning...It's bad in a way cos everybody knows it's there."*
>
> Greyville girls 16+

> *"But the problem if you had one in a small town or village, is that everyone knows everyone else, so just going there would be like a scandal almost."*
>
> Brownton/Pinkham girls 16+

However, others felt that the FPC they used was anonymous and discreet:

> *"Like outside, its just a little plaque on the wall. It's kind of cool cos people don't quite realise where you're going or anything"*
>
> Greenham girls 16+

This group was discussing the Redton clinic and it may be that they were more confident in anonymity simply because it was well away from their hometown.

Waiting Time

The Redton clinic is very well used, and this can lead to over-crowding and long waits, especially if no appointment is made. Some groups saw this as a problem:

> *"When I've been up there before its always been too packed, the waiting room's been like jam packed and you're thinking "I don't want to sit here no more".*
>
> Redton Girls 16+

> *"It's a bit of a waste of time really. You're sat around for half an hour in the waiting room. Its a long time."*
>
> Greenham Girls 16+

It may be particularly difficult for girls from outside of Redton itself to have a long wait at the FPC as they are reliant on buses to get home. A long wait may lead them to leave without being seen.

Misinformation about FPCs

In a few of the groups, the participants were unclear what a FPC was or what services it could offer. The school based survey also showed that a third of respondents did not know what a FPC does. For rural teenagers, distance means that they were unlikely to just drop-in and see what was on offer because it was too far away:

> *"We don't really know what's on offer and what the options are when you get there because you can't get there...because it's far away you don't know."*

> *"Or whether there its a qualified GP sort of person or whether its just a nurse or someone."*
>
> Brownton/Pinkham Girls 16+

> *"Family Planning Clinics, they have the power to prescribed then do they?"*
>
> Greenham boys 16+

The FPC was seen as too distant and thus an unknown quantity – both in terms of how it was staffed and what services they were able to offer. In both these cases, the speakers are unsure whether a qualified doctor is part of the FPC team. These groups were largely reliant on their school nurse or GP for information. Although they had all heard of the FPC, access difficulties prohibited them from investigating it further.
Other groups found the name misleading:

" I always thought the Family Planning Clinic was like for when you wanted a little baby... I thought it was there to help you be parents...."

"I just thought, you know it's like about children...and parents going, like if they're having problems or something."

Pinkham Girls <16

"Give you advice and stuff."

"Help you to plan a family."

"Show you how to look after a baby, feed it, breastfeed it, change its nappies and stuff."

Greyville boys <16

Although most of these clinics now describe their services as "Contraceptive Clinics", the FPC is the name used in phone books and in leaflets and magazines. All the groups referred to these places as Family Planning or Family Planning Clinics. Clearly, teenagers need to be fully informed about what services are available to them before they will use them.

Boy's Knowledge of FPCs

In several of the boys' groups, although they knew that an FPC was available to them, they were unsure where it was located:

Mod: *"Do you know where your nearest Family Planning Clinic is?"*

"Redton I think."

"I don't know"

"I have no idea."

Greenham boys 16+

"You can get condoms for free at the Family Planning Clinic"

"You'd have to find out where it was first!"

Greyville boys 16+

Few of the boys thought that they would actually use the FPC, although a couple had been there with girlfriends. One of those who had taken his girlfriend to the FPC said he always waited for her outside in the car (Redton 16+). Another participant said he would prefer to see a stranger for issues about sex and so would go to the FPC rather than the doctor but this was uncommon.

Problems with Access

For a number of the groups, their access to FPCs was limited. Whilst a FPC away from the home town did offer anonymity, it also made visits a time consuming process:

"The thing about the Family Planning Clinic, it's a bit far out of town, isn't it? ..It's restricted.. Like, I could run there like in an half an hour lunch break! (Pant, Pant!!) "

Greenham Girls 16+

"The only trouble with my area, 'cos like I come right from that end, and it's sort of like, I can't walk up here, it's sort of a bus journey and a train journey ...then it'd be another bus journey to get up there, 'cos I won't walk, it takes too long ...So, you know, it's sort of like. Oh, it's just too long to get up there for me. All I've got is my GP".

Redton Girls 16+

Both of these speakers preferred the FPC when it was possible to use it, but in reality were restricted by the distance between their homes and the clinic.
Opening times also restrict when it is possible for teenagers to use the FPC:

> *"Cos I know a friend that was working and had to go there in her lunch break and we were worried that we weren't going to get back in time, and she couldn't go afterwards 'cos she finished late... so it was kind of a bit awkward, getting the bus as well."*
>
> Greenham Girls 16+
>
> *"There should be more places to get the [emergency] pill on more days, 'cos you can only get it on a Tuesday and what if ...What if it happens like Wednesday?"*
>
> Greyville Girls <16

Access for EC is particularly difficult if there are limited sessions for Family Planning – this is the case for many of the local clinics.
In some of the clinics, other services were also limited because a nurse only clinic operated some of the time and this was also problematic for teenagers:

> *"They don't like, give you the pill though, unless there's a doctor there or something...you have to have a doctor, you know like the blood pressure at the beginning and all that...they didn't have a GP only a nurse so I had to go down the surgery and get it."*
>
> Greenham girls 16+

This girl is unclear as to why a doctor is needed to issue her the pill, and seems unclear about the roles of a FP doctor and a GP. She was unable, however, to get what she wanted from the FPC to which she had travelled by bus, because there were only nurses on duty who were not able to prescribe her the pill. In the end she had to go back to her local GP which was not her preferred service provider.

Key Points

- On the whole, the groups regarded the FPC well, and saw it as offering confidential, specialist and friendly advice.

- Problems centred largely on issues of access, waiting times when attending without an appointment, distance from home and restricted opening hours.
- There was some confusion as to the services offered by a FPC for some, especially if they lived some distance from a clinic. Some did not relate their needs to the name "Family Planning Clinic".
- Although they knew of FPCs, many boys did not know where their local FPC was.
- Some groups felt that using a specialist centre had some stigma attached, particularly for younger attendees as this was a clear admission of sexual activity.

SCHOOL NURSE

The school or college nurse may be a key link for teenagers needing sexual health services. However, the role of the school nurse is not always the same across different schools, and it may depend on the personal interests of the individual nurse, as well as the wishes of the school. This may be particularly true for sexual health matters; not all school nurses have Family Planning Training. Many school nurses do offer information and advice to those involved in sexual relationships, and may provide condoms, pregnancy tests and in emergencies, EC. They will also provide a link into GP or FPC services if required. Some are involved in sex education sessions in school. Unlike a teacher, who acts *in locus parenti* and may be obliged to inform the head or parents about pupils' activities, the school nurse is bound by medical guidelines and should offer patient confidentiality in the same way as other health professionals.

The over sixteen Redton and Brownton/Pinkham groups were recruited through the college nurses and this may lead to some bias in these groups' knowledge and opinions about the nurse. The college nurse at Redton runs a weekly Family Planning session. For the rest of this section, school nurse will be used as shorthand for the school or college nurse.

Awareness of the School Nurse

There were a wide range of attitudes towards the school nurses, both in different locations, and among those who attended the same school. For many participants, the school nurse was the preferred source of advice, as well as for condoms, pregnancy tests, referrals and in some cases EC. However, not all the groups were aware of who their

school nurse was – confusing the name with other staff members who had some responsibility for health issues in the school. Others didn't know what services their school nurse offered.

> ***Mod**: "Do you know who your school nurse is?"*
> *-"No"*
>
> *"I think it might be Miss Brown downstairs from PE."*
>
> *"No I'm not sure, I think she might just be the women who signs you out when you're ill..."*
>
> *"No we used to have one but she left."*
>
> Redton girls <16
>
> *"Mike we're not talking about the first aid people. We're on about the actual school nurse doing the BCG and that."*
>
> *"I thought you were on about the ones in the library."*
>
> Blueham boys <16

The younger Redton girls were unaware that there was a school nurse available to them. This confusion occurred in several of the groups.

Accessibility

Being on site, the school nurse was seen as easily accessible. She can be visited without the need for the formalities of an appointment, the fears of being seen by parent's friends or having to negotiate with receptionists:

> *"This is really convenient [the school nurse]. I mean you just pop in and she gives you all the information you need to know. Also its easier than making an appointment or going to the doctor's and sitting in there for three hours with all these ill people and all you want is advice on going on the pill or something."*
>
> Brownton/Pinkham Girls 16+

Mod:" *Where would you go out of choice?"*

"College nurse...It's nice and easy, innit?"

"I can't afford to go anywhere else."

Brownton/Pinkham Boys 16+

"[The college nurse] is here all week...always friendly, always helpful."

Redton girls 16+

The school nurse was seen to be an easy, informal option for information and advice.

However, of those who were aware of their school nurse, most noted that she was available on site for a limited part of each week, unlike the college nurse. Most school nurses serve several schools:

"She is good to talk to but she's only here [2 days] a week."

Pinkham girls <16

This limited availability obviously restricts access, and some pupils were unsure which days the nurse was available.

Attitudes to Young People

For many participants the school nurse was viewed as someone who liked, understood and got on with young people without judging them. The fact that she particularly worked with their age group was appreciated. Many groups found their school nurse friendly, informal and easy to talk to.

"She's good to talk to....She listens to what you have to say."

Pinkham Girls <16

"She treats you like a person, she doesn't judge you at all."

"She's always really nice."

"She gets on well with young people."

Greyville Girls 16+

"She's very approachable."

Brownton/Pinkham Boys 16+

"She talks about things on your wavelength. She doesn't involve really long words and stuff... She's not like really old fashioned and like if you want to have sex with someone, she won't like use, well not use it against you, but she won't judge you."

Greenham Girls <16

"I think out of all the three choices [GP, FPC, school nurse] she's probably the easiest to talk to...she has a laugh and joke with you as well."

Greyville girls <16

Where she was used, the school nurse was seen as a relaxed person to deal with, and importantly, was viewed as someone who would be happy to discuss problems and provide information as well as services.

The school nurse was also seen to offer a personal service. Although some of the schools have large student numbers, she was felt to have time for those who went to her for help. There was a positive sense of building a relationship with the school nurse:

"She makes more of an effort to see people out of college as well...she'll give you her telephone number if it's a real emergency, a real crisis you're in."

Brownton/Pinkham girls 16+

"I reckon I would speak to the school nurse...I've known her virtually all my life"

Greyville Boys 16+

It may be that being based in school, rather than the wider community like other medical services, provides a sense of security. There is less chance of being seen by relatives or friends of the family in school which is the young people's own environment.

The school nurse was also a useful link into other services:

> *"She was really kind...she looked after her and booked her an appointment and she was going to take her in herself to the FPC."*
>
> Greenham Girls 16+

This link to other services, and the availability of information where the teenagers are anyway is particularly important to those living in rural areas. Many teenagers have no services in their hometown or village, except in some cases the GP and have to be bussed from outlying areas to the school itself.

Boys' Attitudes

There were some reservations among male participants about the school nurse as a source of information and services. In some cases, the same nurse invoked totally opposite reactions from boys' and girls' groups. Despite the positive response from many groups, boys were often more ambivalent about the school nurse than girls:

> *"I can't see someone actually going to the school nurse and asking....It'd be too embarrassing."*
>
> *"It's involved with school so that kind of warns me off a bit."*
>
> Greyville Boys 16+

One girl described how she supplied boys too embarrassed to see the nurse with condoms. She identified this as being because the nurse was female:

> *"I don't think it would hurt to have a bloke up here for the boys to see...One of my male friends asked me to come up and get some condoms for him today, because he won't go and see [the school nurse] he's like "It's a woman, I can't ask! They'll know what I'm getting up to won't they?"*
>
> Redton Girls 16+

Confidentiality

As someone attached to the school, some participants linked the school nurse to the school authorities, which they distrusted. Not all the groups were clear about how

confidential a school nurse could be, and there were concerns that she would be obliged to tell the head-teacher about consultations:

"Its not confidential is it? She'll have to go and tell the headmaster."

Greyville Boys <16

"Suppose they go and tell the headmaster? I can't trust my headmaster as far as I can spit!"

Blueham Boys <16

"She might get chatting with the teachers...talking about your problems over in the staff room."

Greenham Girls <16

As with most concerns about confidentiality, these were more acute among the under sixteen's. These comments show both concerns about who the nurse is accountable to and her responsibility to involve teaching staff, as well as more general worries of the kind seen for all health professionals; that gossip in social situations or personal networks might threaten confidentiality:

"I couldn't trust our school nurse because she's the mum of one of my football team."

Blueham Boys <16

"Her daughter's at my school. And she could slip it out one day."

Greyville Boys 16+

"I avoid her, but it's cos she's like my friends mum and stuff."

Greyville Girls 16+

Again, these groups were unsure about the nature of professional confidentiality and assumed that it would not extend to personal relationships. However, one girl reported a very positive encounter with a school nurse despite knowing the nurse in an out of school context:

"She's known me since I was like 11 and ...when I went to see her and I was worried that I was pregnant, and she was fine and really nice and it hasn't affected anything. Like when I see her out of school, she's still the same towards me.

- That's because she's a professional."

Greyville girls 16+

It is interesting that this lack of judgement, and ability to combine personal and working encounters is identified by the groups as indicative of professionalism.

The Role of the School Nurse

In some groups there was scepticism about the professional training and qualifications of the school nurse. They were uncertain what her actual role was and what she could actually provide. They perceived her role as extremely limited:

"She's not a proper [nurse]."

Greyville Boys 16+

"She won't do anything, she won't even give you a bloody aspirin, even a Tic-Tac. They won't give you anything from the school. You have to sign a receipt for a plaster!"

Greyville Boys <16

"She'd just send you down there [FPC]"

Greyville boys 16+

***Mod:** "Did you know she has condoms?"*

"Does she? Wow!..."

"There'll be a queue at the door now!"

Greenham girls 16+

Some also thought she might be limited to helping only older pupils:

"I wasn't sure she would give it to you if you are under sixteen."

Greenham girls <16

Where there is a sixth form or in college, nurses tended to have more freedom to advertise their sexual health role because more pupils are over 16. One group reported a quiz in the sixth form in which the nurse had given condoms as prizes (Greenham Boys 16+). In the colleges, the nurse came round to classes to distribute condoms where wanted and to remind students of her role.

Key Points

- The nurse was a preferred source of information and services for many of the participants who found hers to be a convenient, friendly and helpful service.
- Not all pupils are aware of the role of their school nurse.
- Participants were not always clear if a confidential service was offered by the school nurse, or if she was independent from other school staff.
- Some participants questioned the school nurses' skills and qualifications.

YOUNG PEOPLE'S SERVICES

As well as the youth orientated service provided by school nurses, most youth workers and youth clubs provide information and condoms to young people. In addition, participants from different locations had access to a different range of community services that were aimed specifically at young people. All the FGDs took place in locations close to the study TACs. Blueham has lunchtime FPC drop-in once a week at the local college, as well as an afternoon FPC drop-in at a Health Centre. Greyville has a weekly drop-in at a young people's café. There are no extra community services at either Greenham or Brownton/Pinkham, although Greenham based teenagers often travelled to another town to go to socialise, and there is a teenage drop-in there. Redton does not have a young person's clinic, but the FPC attracts a large number of teenagers.

Opening Times

There were mixed feelings about services specifically aimed at young people both between groups and within them. One of the problems seen with youth services was that

they tend to be open for limited sessions, often (like TAC) just once a week. In some cases they were staffed only by nurses, so also offered limited services – for example advice, condoms and EC, but not other sorts of contraception such as the pill or the injection. This had been a source of frustration for some:

> *"I got the morning after and I said, "Well, when can I have the pill"? And she's "Come down on Tuesday" and it was a Thursday or something and I wanted it now."*
>
> Greyville Girls <16

Teenagers may not return for follow up appointments.

Limited opening hours can lead to confusion as to when a service is available as this discussion about one of the TAC sessions showed. Although most had seen the posters and stickers advertising the service, they had not absorbed the details:

> *"Thursday?"*
>
> *"I thought is was 24, no it can't be 24 hours a day!"*
>
> *"Is it 12 hours a day?"*
>
> *" Is it at the end of school?"*
> *"Yeah is it after school?"*
>
> Brownton/Pinkham Girls <16

As young people may need to build up their courage for a visit, they may lose interest if a service is not available at the time the feel ready to go. For emergency contraception, timing is obviously very important.

Accessibility

As with all the services discussed accessibility is important, particularly for rural teenagers as these contrasting quotes show:

> *"It's right next to the youth club which is quite a handy place isn't it?"*

Greenham girls 16+

"If I cycled there [TAC] it'd take about five hours!"

Pinkham girls <16

The participants were aware of how limited their access was to some places, and many felt that there should be more young people's services set up in local towns and villages so that all teenagers were within easy reach of a specialist service:

"There are opportunities...it's just that some people can't or won't...it just needs to be more available."

Brownton/Pinkham girls 16+

"They can't get to places, so they should do one [here]."

Pinkham girls <16

Advertising

As well as increasing the number of local teen-orientated services, most groups thought that all the services needed to be more widely advertised, including producing prominent information indicating that under sixteen's were welcome. However, participants were sensitive to what they saw as the patronising style adopted by some places that wanted to attract young people:

"But, don't you think sometimes, the, all these sort of youth, young people's sessions that get run, that sometimes they're just really over-simple and patronising...sometimes you know, they think "Oh, let's make our language really cool, and give out jazzy leaflets" in the hope that it's, you know, going to make everyone go, "Oh right ....""

" It would actually be really cool to go to the doctor's!"

"You know, really fun."

"...Sometimes you can just see straight through it..."

"... You know it's not really aimed at us it's aimed at what grown ups think we want."

Brownton/Pinkham Girls 16+

Young people are savvy consumers, and well used to the ways in which advertising tries to engage them. There is a warning here that services need to genuinely consult with young people both to establish their needs and design appropriate publicity. They are also not going be conned into believing that a service is something it is not. Going to the doctors is never going to be "cool" but it may still be a useful place to go where teenagers can expect a helpful and respectful service.

Service Style

Where there were specialist services that participants had direct experience of using, several problems were identified. One group felt that a session held at a local youth café was too informal. Whilst the café was well used by young people, this group did not feel that it was an appropriate place to bring problems, especially serious concerns. Trying to mix a service with a social venue may lead to the service not being taken seriously.

"People say it's good like, but [four days a week] you have like an open Cafe. So everyone comes in and mucks about ....I think there should only be like the doctors or something to go to, to get like advice and stuff like sex and stuff. If you come down here like with your mates, and there's loads of other people down here and they're talking and that stuff and you're laughing and giggling and all weird stuff like that, you're not going to take it serious are you?"

Greyville Boys <16

This is clearly problematic for those who are trying to bring services to more informal settings where young people already congregate.

Boys in particular are often under scrutiny from their friends and may not feel able to use services in such an arena. Much work would need to be done to ensure that such provision is regarded as a quality service; as confidential and professional as more mainstream services.

The fact that TAC had made an effort to separate its services from the rest of the practice was appreciated by some:

"There's a door on the way to reception, so it's like, safe."

Greenham girls <16

This helps to alleviate anxieties about been spotted in the waiting room of the GP.

Staff

Several groups mentioned peer workers or peer educators as appealing, although again the reception was mixed. Some felt that young people were easier to talk to, and that their advice could be more appropriate to them, particularly if they had experience of similar problems.

"I think more people our age need to be involved. There needs to be some sort of, I don't know, organisation or something where you can talk to other people your age but know what they're talking about it a way, I don't know... especially if there's been someone in the same sort of position as you and they've handled it one way and then they, they're willing to give you advice." Brownton/Pinkham girls 16+

However, others felt that peers were not appropriate and they had difficulty accepting the information offered to them by someone not much older than they were:

"I don't think [peer counselling] is very good. I reckon you've got to turn to an adult or something like that to talk about it instead of children."

Greyville boys <16

"We had a load of students...only a year older than us thinking they knew everything about it!"

Redton Boys 16+

Interestingly, although this latter group found it hard to accept the validity of information provided by peers in a formal setting, they were very happy to use one member as an informal "agony uncle". This student was slightly older than the rest of the group and several others said they turned to him for advice about relationships and sex. The training and credibility of any peer workers used needs to be given careful consideration.

More groups were interested in workers who were "young" or just familiar with young people and their attitudes.

"Get some new [doctors]."

"Younger."

" Cool."

Greenham girls <16

"They're used to all students...they've got experience, training."

"They wouldn't ask questions 'cos they know we'd be embarrassed."

Redton boys 16+

Several of the boys groups picked up this theme of discomfort with being questioned. They would prefer to be simply given condoms without having to account for themselves:

"I think having someone to talk to if you wanted to is a good idea but you shouldn't be made to talk to them."

Blueham boys <16

Fear of being asked inappropriate or embarrassing questions about themselves prevented some of these boys from using existing services.

On the whole, girls were more concerned that receptionists should refrain from questioning them than of being questioned in the consultation:

"[Receptionists] shouldn't ask "Well, what's wrong with you?", they shouldn't make you feel uncomfortable."

Brownton/Pinkham girls 16+

Girls usually preferred service providers to be interested in them and wanted to be able to have a discussion with them.

Key Points

- There were mixed feelings about youth dedicated services in the groups. Some were well used and staff experienced with youth issues were appreciated. There were calls for greater numbers of youth services to be on offer.
- Problems of access because of session timing and distance restricted some teenagers from approaching them.
- Credibility was also an issue – both in terms of the informality of the setting and when services were limited because of staffing.
- Advertising should be explicit and widespread.

Theme 2: other sources of advice and guidance

Teachers

Teachers were rarely mentioned as sources of help and information in the context of sexual health. Although teachers had given most participants at least some of their sex education, this was usually the only context on which they mentioned talking to them. As evasion and embarrassment on the part of teachers had often marred their sex education, teenagers did not on the whole feel comfortable approaching them further. Indeed, most preferred having an outsider provide even the sex education.

Difficulties talking to teachers

School wasn't seen as somewhere it was easy to get private time with a teacher, even if they would like to do so:

> *"[Teacher] said if we've got anything we want to speak to him about...*
> *- But it's really difficult and that, there's always other people. When it comes to it you can't."*
>
> Pinkham girls <16

Most teachers don't have offices, and classrooms, corridors and staff rooms are not suitable for private conversations.

Several groups were critical because questions that students had put to teachers in sex education lessons were not followed up:

> *"We did three questions on a piece of paper didn't we.....they wouldn't answer [all of them], but they could have been serious ones and they just didn't take them seriously or something."*
>
> Greenham girls 16+

> *"They spend a whole hour telling us and then we ask something and they're like "Shut up we haven't finished yet."*
>
> Greyville girls <16

Without open communication about sexual matters, teenagers are unlikely to feel encouraged to approach teachers with personal problems.

Another group's experience contrasted strongly with this, as they had a teacher who was open and at ease with the topic:

> *"We just had a really good teacher I think, didn't we?...she thought it was fun...she just talked about it really personally like, in her own language."*
>
> *"She obviously had a very healthy sex life!"*
>
> Brownton/Pinkham girls 16+

This relaxed attitude was much appreciated by these girls, although in fact none of them had talked to her subsequently about sex related matters.

Perhaps because of the "them and us" structure of schooling, many of the groups did not feel that the teachers were really in touch with them and their lives. This again limits the opportunities for honest revelations:

"Because I am going to be talking like this in front of a teacher, I mean!" [laughter]

Blueham girls <16

"We told [teacher] "When are we going to do drugs then?" he went..."We're not doing it 'til Year 11." I went "Well we need it now"...he goes "There's no drugs in Greyville anyway.""

"Yeah and then we were like "Well what do you know?""

Greyville girls <16

The speakers do not believe that this teacher has anything to offer them about the realities of drugs as they see them and so not a reliable source of information about their concerns.

Another teacher was seen to be disapproving of sexual explicit material:

"He found us reading magazines and stuff that had everything about sex...like problem pages in 'Sugar'...that thing in 'Just Seventeen', they read it out in assembly about your perfect boyfriend or something like that...that one in 'More' magazine, you know that's got like positions...he said it was pornographic."

Greyville Girls 16+

This led the group to conclude that the school was disapproving of sex generally:

"They can't really put posters up around school saying "Family Planning will give out condoms and advice and that" can they 'cos it's just not the right type image."

Greyville girls 16+

The best interests of the pupils and those of the school are seen to be at odds.

Confidentiality

Some groups were explicit in their distrust of an enquiry to do with sex staying confidential if they took it to a teacher:

> *"If you want to speak confidentially then teachers aren't good 'cos they reserve the right to speak to who they like about problems with pupils that affect you...they're not necessarily going to keep it to themselves. You might think they are but, so I reckon teacher's a dodgy one."*
>
> Greenham boys 16+

> *"I can't trust my headmaster as far as I can spit!"*
>
> Blueham Boys <16

In most cases, this distrust is well founded – teachers are often required to reveal information about pupils to the head who in turn may be obliged to speak to parents.

Key Points

- Teachers were not seen as sources of advice about sexual issues.
- Teachers were often characterised through their lack of openness in sex education classes, or other judgmental attitudes.
- Problems of finding a private place to talk in school and concerns about teachers confidentiality further mediate against it consulting them.

Parents

Some research suggests that parents and children have different ideas about what they can and do communicate about. One study suggested[93] that far more parents thought they had talked to their children about sex, relationships and HIV than their children recalled. Some groups did, however, cite their mother as the first source of information about sex when they were younger.

> *"I'm close with my mum and my mum told about like sex education when I was 8 or 9 'cos she wanted me to know about it."*
>
> Greenham girls <16

In addition, several of the girls knew about specific issues such as smear tests, coils or caps because of their mother's experience. This suggests that some young people can and do discuss some sexual matters at home.

Fear of Parents' Reactions

On the whole, however, the groups did not see their parents as a suitable source of information or discussion. It was a source of regret for some and several groups did express a wish to be able to speak to their parents about relationship and sex issues.

> *"I wish I could talk to my mum, I really do, but..."*
>
> Redton girls 16+

Many of the fears that these teenagers had about using local health services were primarily to do with the fear that their parents would find out that they were sexually active. This suggests that few feel they can talk openly to their parents if they are having sex. Asked who they would suggest a friend talked to about contraception, one boy responded:

> *"You've got to be realistic because you can't say like...teacher or your parents or something like that 'cos there's no way they're going to go and ask them."*
>
> Greenham boys 16+

The under 16s in particular felt it would be difficult or embarrassing to do so and were afraid that their parents would be angry with them. Participants were also aware that some people had much more open or close relationships with their parents than others – with some describing being permitted to stay over at their boyfriend's house or their mum coming with them when they went on the pill.

Fear of their parents' reaction could over-shadow teenagers' need to talk to their parents if they were in trouble as the following quote, in the context of a unplanned pregnancy, shows:

> *"You're not really independent, I don't think. Maybe you would sit there if you were 15 and go "Right, well, my options are this, this, this and this" and go through it in a logical manner. I think you'd just think "Oh God! They're going to kill me!"*
>
> Brownton/Pinkham girls 16+

Of the scenarios discussed, only the one relating to an unplanned pregnancy invariably elicited responses about parents and most were scared of the reaction that might be evoked.

> *"That'd be the hardest bit, telling the parents, fucking hell!"*
>
> Redton boys 16+

The perceived reaction of parents to a teenage pregnancy was fairly consistent across all the groups. Most mentioned the possibility that they would be thrown out, or that their parents would be furious or "have a heart attack"; many thought their fathers would be angry or even violent towards them or towards their boyfriend if they were female. They also thought they would be lectured and shouted at. Several groups had stories to counteract these perceptions, which recalled friend's parents being unexpectedly supportive, but the uniformity of response suggests that this is accepted folklore at the very least. Because of these misapprehensions some participants regarded their parents as the last resort, only to be approached if all else had failed.

Parents' Expectations

Many female participants felt that their parents found it hard to accept that they were growing up, with fathers in particular thought to nurture the idea that they were always their "little girl". Several participants felt that their parents had unrealistic expectations of them:

> *"My mum thinks I'm going to stay a virgin 'til I'm 32."*
>
> Greenham girls 16+

Not all parents' approaches to talking abut sex were felt to be helpful by participants. Discussions may reveal parents to have expectations of their children that they don't feel able to live up to. In this case teenagers were unwilling to discuss actions because they already had the impression that their parents would be upset or disappointed because they didn't approve:

> *"If she's been going through your life saying "Don't do it until you know it's the right person and you really love him, and wait until you're 16 else you're not*

legally allowed to" and all that stuff like, you wouldn't really want to tell her that much."

Greenham girls <16

Teenagers might then feel that they needed to protect their parents from information that they would rather not know:

"I'd go to my mum an that for a long term relationship or something, but if was like a one night stand I wouldn't."

Greyville boys <16

The participants felt they could not be honest with their parents because parents would feel let down by their behaviour.

Lack of Privacy

In other cases parents were felt to be unnecessarily intrusive on their children's relationships:

"If we [speaker and boyfriend] go upstairs my mum creeps up to the door and opens the door "Oh! Would you like a cup of tea?" She doesn't knock and wait for you to say come in, she just knocks and like [mimes rapid door opening]!" [laughter]

Greyville girls 16+

This kind of suspicion and scrutiny made the speaker unwilling to discuss her relationships with her mother.

Key Points

- Some participants reported that they were able to be frank with their parents, especially their mothers about sex, but this was the exception rather than the rule.
- Involving parents was often seen as a last resort that would only be undertaken if there was nowhere else to turn.
- Teenagers are embarrassed and scared of their parents being censorious.
- Younger teenagers were particularly concerned about their parents' reactions.

Youth workers

Youth workers were mentioned as a source of possible information and advice by many of the groups. This may in part be due to the fact that some of the groups were recruited through youth workers. They might not be truly representative of the proportion of teenagers who have contact with youth services (for example, none of the Redton groups, which were all recruited though educational establishments, made any mention of youth services). However, all the Blueham groups, the younger Greenham groups, all the Greyville groups and the younger Brownton/Pinkham girls were recruited through youth workers. Most of the participants in these groups were aware that youth workers could supply condoms, and in some cases pregnancy tests for free.

Some participants found youth workers very useful as someone with whom they could talk over problems.

> *"You can just sit here and talk to them and not feel embarrassed, you just feel really relaxed and comfortable...They're down here every [weekend]and if you've got any problems over the weekend you just come in and talk to them and they sort it out for you and they just listen to you as well."*
>
> Greyville girls <16

Youth workers were valued because they were not attached to formal education or health services. The support offered is often informal and participants were pleased that youth workers were available simply for a chat and to try and cheer them up:

> *"[Youth worker] can make you laugh..."*
>
> *"Yeah"(in unison)*
>
> *"...if you're really down and depressed..."*
>
> *"He just puts a smile on your face."*
>
> *"...he still makes you laugh."*
>
> Greyville girls <16

Youth workers are often interested in teenagers' well being and this is clearly appreciated. Participants were positive about the availability of a neutral, concerned adult with whom they could build a relationship. They were seen to fulfill the criteria that teenagers have for adults they will trust (they don't patronise, listen to what teenagers say, and combine adult experience with the ability to relate well to this age group.)

Key Points

- Youth workers were well regarded as a source of advice and support, although clearly would need to refer teenager on to other services for some types of problems.

FRIENDS

Girls' Friends

For many of the girls, support from their female friends was an important lifeline if they had problems or just wanted to talk. Friends were seen to offer support and in some cases, specific information. This was particularly true if they had already been in a particular situation or had used services before. These experiences are shared. In addition, they would not judge behaviour from the same perspective as professionals or other adults:

> *"If you're friends, they're not saying "It's illegal" they are giving you the other reasons."*

Girls' friendships often specifically revolve around sharing of confidences. The ability to trust someone was seen as an important prerequisite for friendship:

> *"You've got to have friends I reckon."*

> *"You've got to make sure they are someone you can really and truly trust...you've got to make sure like if you fall out with them that they won't tell someone."*

Greenham girls <16

Friends were also important because they would listen to problems and respond to the needs of that particular person, as well as the situation:

"You need someone who knows you, knows what you're like."

Brownton/Pinkham girls 16+

The girls in these groups relied on their friends to be honest with them about situations and relationships, and valued close friendships where this honesty was possible:

"I think personally it's better to have someone that knows you, because you might have this idealised vision of what it's going to be like and I think you need someone who sort of knows the negative sides that you might not be putting across. To say to you, you know "Well I don't think he's the right person for you..."

"Yeah some negative things are better coming from a friend than a stranger."

Brownton/Pinkham girls 16+

There were clearly some skilled listeners among the participants who wanted to make sure their friends kept safe and happy. The following quote was one girl's response to the first scenario, where her friend was unsure about having sex for the first time:

"I would just chat to her and sort of see why she felt like that, like how she felt about it and like find out, there has to be a reason why she doesn't, she's a bit apprehensive about it.....If it's that she feels pressured into it then I'd sort of say "Well, if you don't want to, then you don't have to, you know"

Greenham girls 16+

This girl is effectively offering counselling – listening, identifying the root of the problem and offering support for her friend's decision. In other cases, especially in the case of unplanned pregnancy, girls assumed a friend's role would be in understanding and problem solving and that support and empathy would be required:

"Discuss what you can do basically."

"And try and offer as much support."

"Yeah, just be supportive"

"Go along with her. Cry a lot!"

Greenham girls 16+

In one group, the discussion precipitated the continuation of a conversation between two friends who had clearly spoken on the same topic many times before:

"What's wrong with having [sex] unprotected?..."

"Oh I'm not going to say it 'cos it'll just get into a big argument.....OK then, when I, why, why do you ask for our advice if you're not going to listen to it?....I mean you go in for advice and then you go and have it unprotected."

Greyville girls <16

The second speaker is exasperated by her friend's inability to follow the advice she has been given to protect herself. This is a breach of unspoken friendship codes. Asking for, giving and respecting each other's advice is often part of an informal contract between female friends.

Often, friends accompany each other to health services in order to provide moral support. On occasion, they are crucial in ensuring that someone reaches the service needed:

"You need to go for a pregnancy test....she just dragged me in there with her!"

Redton girls 16+

Other people's experiences of situations and services were felt to be invaluable. Throughout the discussions of their friends, there was an emphasis on sharing (information, experiences and emotions.)

Boys' Friendships

The dynamics of the friendships described by girls and boys was very different. This was also visible in the way that the groups themselves operated. Girls' groups were often confiding, and they frequently talked about their own experiences. They were mostly keen to voice their opinions. In most cases, longer discussions without any input from the moderator occurred within the girls' groups. This could however, have been the effect of a female moderator. In addition, it was clear in girls' groups that many of the topics discussed had already been raised among themselves. Although the moderator always initiated scenarios at one remove (that is asking them to think about what a friend should do) or how they thought teenagers generally felt, girls' groups usually quickly dropped this and responded with information about themselves and their own experiences. By contrast, discussions in the boys' groups were more likely to revolve around joking and teasing among themselves, with answers often restricted to quips in the first instance. The moderator had a greater role in drawing out their opinions, and getting them to expand their responses.

As has been discussed earlier, many boys did not believe that they could confide in their friends. Their fear that they would be exposed and ridiculed prevented most groups from regarding their friends as a source of support:

> *"They'd just take it as a joke."*
>
> *"They don't really listen to you"*
>
> *"They listen to you but they don't take much notice, they think it's a joke and they muck about and that and they'd probably go and tell someone something or the other."*
>
> Greyville boys <16

Although most said they had someone among their friends that they could confide in or that there were some things that would be kept private, these boys often didn't trust their friends not to use information against them even in the face of quite serious problems.

Boys also thought the temptation of having something juicy to tease friends with or gossip about might overcome their own ability to keep quiet about a friend's problems:

> *" If someone told me something serious then I'd keep it serious I won't tell nobody, like if someone came up to me and goes "Ah, my bell's sore" then I'd like accidentally slip it on. But I wouldn't tell like if it was a family problem or something really personal."*

> *"You could tell some of your friends and they'll keep it quiet, even if you are joking about, but if you're not joking about and like you say something, they'll just go, say you got a girlfriend pregnant and that and you didn't want nobody to hear about it, it'd be going round the school and that, just get out. And everybody taking the mick out of you and saying stuff and that."*

Greyville boys <16

Despite the first speaker's protestation that he wouldn't gossip if a friend's problem was serious or personal, he admits he would talk about a potential STI. The second speaker doesn't see how a pregnancy could be kept secret. In both cases, information is described as being "slipped on" or just "going round" rather than actively passed on.

On the whole, boys were less sure than girls that their friends were good sources of factual information, as well as advice:

> ***Mod**: "How good a source of information do you think your mates are?"*

> *" Not very good."*
> *[laughter]*

> *"Total bollocks!"*

Blueham boys 16+

This is in contrast to the girls' groups who mostly thought that they would be able to get good factual information from their friends in addition to relying on them for emotional support.

Boys didn't on the whole feel as though they could speak to a female friend about personal problems either:

"I've got a few [female friends] but I wouldn't talk to them"

"Just chat them up!...."

"It'd be weird wouldn't it, telling a girl that you'd got a problem, like they wouldn't understand would they? Cos they're not equipped like you..."
[Laughter]

"...I wouldn't really go and speak to a female friend 'cos I don't understand women so I couldn't speak to them."

Greyville boys <16

These boys are happy to reinforce perceived gender differences (men and women don't understand each other, and primarily interact in ways that are sexually charged) They seem not want to challenge the assumption that the sexes are fundamentally different and unable to helpfully relate to each others concerns and needs.

Some of the girls' groups also recognised differences between their own friendship networks and those of the boys:

"I think most boys don't really have any really close mates, do they? They're just gangs, aren't they?..."

"I reckon boys are too afraid to go and speak to someone about it anyway, they don't, its not cool enough...."

"Boys talk about image...."

"They're not as confidential or close as girls are."

Greenham girls <16

The limited ways in which male friends are seen to relate to each other mean that many boys are very limited in who they think they may be able to turn to if they are worried about anything.

Key Points

- Most girls' groups placed significant value on friends as sources of information, advice and just as a listening ear.
- Boys often felt unsure about who they could trust with personal or confidential information. There were concerns that they would not be taken seriously or that information would be passed on as gossip around the school.

Boyfriends and girlfriends

Some groups had to be prompted to think about boyfriends or girlfriends as someone they would talk to in any of the sexual health scenarios. Even in the case of having sex for the first time or an unplanned pregnancy, not all the groups spontaneously mentioned partners as someone they would advise their friend to talk to:

"Advise them to tell their parents....."

***Mod**: "Anybody else you would talk to?"*

"A doctor, get some good information."

***Mod**: "What about their partner?"*

"Well yeah, advise them to talk to their partner."
[Laughter]

"I forgot that!"

Redton girls <16

In addition, girls' groups in particular were aware that there were different types of boyfriends who may or may not prove helpful at times of need. Particularly in the case of an unplanned pregnancy, girls felt they would need to assess the state of their relationship as part of deciding what course of action to take:

"It also depends on like whether you've got a reliable boyfriend....not someone that like when you're just about to drop like, will go "Ah fine, see you later"

Redton girls 16+

"If you talk to your boyfriend, then you know, you don't know what he's going to think of it."

"Yeah, I know, you don't know if they'll just like run off."

Greenham girls <16

All the girls' groups mentioned the possibility that a boyfriend might not stay with them if they became pregnant.

There was also wide recognition that all relationships were not equal; different boyfriends, different lengths of relationship and sex outside an established relationship had different impacts. Long-term boyfriends were expected to be more involved in decision making. However, in several cases, the girls described any expectations they had about being close to their partner or should being able to work out problems together as the "idealised" viewpoint:

"It's a pretty idealised view but if you're quite close to him anyway. You're supposed to be – having a sexual relationship with him. That he is close enough for you to tell him something important. Otherwise I think it's a quite pointless relationship."

Brownton/Pinkham girls 16+

Other group's discussions showed that this ideal of a close special relationship with a sexual partner had already been shown to be unrealistic for some of them:

"Sometimes like, you do it with a boy and they're like, the next day you're like worried about it but you can't talk about it with them because you don't know him, like they might be a friend or something but you know they won't talk to you. They'll like go and do it with another girl..."

"Yeah"

"...and you like just feel like crap."

Greenham girls <16

Some sexual encounters are with virtual strangers, which makes communications about sex very difficult for any age groups, but especially for teenagers.

In addition to finding it hard to talk about personal issues with some of their sexual partners, many were also concerned that boys would boast about their sexual conquests. In fact this was borne out to some extent by the boys' groups. Although few said they would talk to their friends about having sex for the first time before it happened, most said they would tell their friends about it afterwards:

"You'd have to be a really strong person to keep it to yourself I think."

"It's your first time. You want to go around telling your mates."

Greenham boys 16+

This reinforces the limitation which boys were seen to put on their communications with friends – fears or personal issues are taboo but bragging is inevitable.

In other scenarios, many girls' groups felt that boyfriends were not really concerned about issues such as contraception and that they didn't anyway have any information to share about it:

"It's just like they're just like completely not bothered anyway..."

"I think they're a bit ignorant of the facts as well."

"... It's completely up to you if you do anything [about contraception] cos like, he like won't play any part in the decision."

Greyville girls 16+

Boys' groups more often mentioned their girlfriend as someone to talk to about problems than girls mentioned boyfriends. In the case of an unplanned pregnancy, almost all boys regarded the final decision as belonging to the girlfriend. For some boys, their girlfriend was a crucial support, and occupied a privileged position, different from other friends – male or female.

"I've got [female] friends but I wouldn't speak to them.....You would? Who would you speak to amongst your friends?"

"Who do you think?"

"Well yeah but you're going out with her, aren't you?...That's different."

Greyville boys 16+

Key Points

- It was difficult for many participants to imagine speaking to a boyfriend or girlfriend about sexual issues.
- Although some girls were positive about being able to talk to serious boyfriends, more felt that boys were not interested, were too embarrassed or too ill informed to be helpful.
- There was recognition that casual relationships may involve considerable communication difficulties.

Theme 3: barriers to service use

A number of factors were perceived by young people as barriers to using the sexual health services that are available. This section will summarise the main problems that were identified by the participants. There is some repetition with the service specific comments already reported but often, they are problems which teenagers have regardless of which service is in question. Some of these barriers are psychological or personal (relating to their own embarrassment, confidence or lack of knowledge about what was available). These will be referred to as "internal barriers". Others were to do with the services themselves (who staffs them, where they are or what services they offer) and these will be referred to as "external barriers."

Internal barriers

It is important for service providers to recognise the amount of trepidation that many young people feel when approaching about sexual health issues. Actually going to a health care setting is fraught with uncertainty, and teenagers are often very apprehensive

about the reception they might receive. These girls, asked for one prime cause that prevented people seeking help, fell over one another to describe their concerns:

> ***Mod**: "If there is one thing that stops people using services, what would you say it was?"*
>
> *" Just being embarrassed really."*
>
> *"Intimidated."*
>
> *"What they might say back."*
>
> *"Privacy, privacy and whether they're going to judge you because of what you've done...."*
>
> *"Judgement."*
> *"..Judgement. What they are going to think of you."*
>
> *"They like, if they come round and say, its like "Tell your mum" or something "I think you should tell your mum" Its like, oh you don't know my mum! [laughs] But it's not that easy."*
>
> *"But some people can be really kind of horrible. You don't know under what circumstances you've got this problem and what situation you're in, and you go and it could be kind of not your fault and, or you could have just been careless but you sort of seem as if everyone's judging you for being really careless about it. It's just quite intimidating."*

Greenham girls 16+

The list of possible negative outcomes here is long. Teenagers are initially embarrassed about talking about sex and revealing that they are sexually active. In addition, they are uncertain of the reaction they may receive. Being judged negatively, spoken to harshly, or blamed for their actions, or being told to inform parents when this feels impossible -

all emerge as concerns in any encounter. Fear of all or any of these possibilities has to be overcome before teenagers will present themselves at a service.
This section will consider

- Embarrassment
- Fears around confidentiality
- The desire for anonymity
- Fears about provider attitudes

Embarrassment

Many people, and teenagers in particular, find it difficult to seek help about personal issues. The FGDs cited embarrassment and apprehension as a major barrier to their use of all services and professionals, particularly the first time. Embarrassment can accompany almost any stage of the visit – from asking for an appointment, to being seen by a friend in the waiting room, to describing to the doctor or nurse what is wanted or going in the chemist for a prescription. Embarrassment was mentioned in relation to all of these circumstances. The girl below was describing getting condoms from the school nurse:

> *"It's like the first time I asked for condoms, what was it I was like? I just put a blank on. I went "Oh no, did I really just ask for that" it's like you know, "Oh my God!"*
>
> Redton girls 16+

Embarrassment is linked to that generally surrounding sex, and the tacit admission of sexual activity. However, some knew rationally that they shouldn't let it affect them:

> *"You go in there and you think "She knows I'm having sex!" you know, its really embarrassing, oh my God, you know. But its not, she's not going to care is she? She's given [condoms] to hundreds of people, I'm sure."*
>
> Brownton/Pinkham Girls 16+

Despite her logic, this girl found the encounter acutely embarrassing

Gender Differences

Most of the boys' groups were embarrassed by the idea of seeking sexual health advice from anyone:

> *"I can't see, like, someone actually going to the school nurse and asking. Well, it'd be too embarrassing..."*
>
> ***Mod:*** *"What, embarrassed talking about it or just going there?"*
>
> *"Yeah, well both really."*
>
> Greyville Boys 16+
>
> *"I'm too embarrassed to go to the doctor's for anything like that."*
>
> Brownton/Pinkham boys 16+
>
> *"If people see you going in it's embarrassing."*
>
> Greenham boys <16

In two of the boys' groups it was suggested that girls were less likely to be embarrassed about sexual health issues.

> *"Girls aren't shy about things like that."*
>
> Redton boys 16+
>
> *"Girls see the doctor, but not all males will. They kind of think "I'm too embarrassed to go and say it"*
>
> Greyville boys <16

This assumption was seen as a reason for girls being more willing to attend sexual health services.

Some of the boys were particularly unnerved by the idea of being asked questions by a health care professional, and wanted to be sure that they would not be obliged to discuss anything:

"I think the idea of having someone there that you could talk to if you wanted to is a good idea. But you shouldn't be made to talk to him."

Blueham boys <16

"They shouldn't want to know everything about you. A lot of places want to know everything about you and it's a bit, you don't really want that all the time do you?"

Redton boys 16+

Extra questions lead to more embarrassment. It should be noted however, that the latter speaker had never used any sexual health service, but was put off by the thought that he might be expected to discuss his personal life. Most thought that boys were more reserved than girls:

"[Boys] like to treat things more privately than girls as well. Well some sort of things they prefer to keep private."

Greyville boys 16+

Since many of the boys were particularly worried about not revealing personal details about themselves or their behaviour, they found the idea of consulting someone about sexual matters particularly embarrassing.

In some cases, the gender of the health professional would affect their levels of discomfort:

"You don't feel like talking to a man about that sort of stuff.... 'Cos you get embarrassed."

Blueham girls 16+

"I'd laugh if it was a woman and then I'd look like a complete and utter retard".

Blueham boys 16+

One group of boys felt that they would be more embarrassed talking to a young woman than to someone older. On the whole, girls preferred to speak to a woman, but there were exceptions such as if they had already consulted their male doctor and found him

sympathetic, or if they had an existing relationship with a male youth worker that they trusted. Boys were more divided, with most preferring to see a man, but others feeling that a woman would be more approachable.

> *"I'd rather tell a woman than a bloke. I don't know why."*
>
> Blueham boys <16

Getting Over Embarrassment

The groups saw that confidence was required to get over the embarrassment and fears that young people have about approaching service providers:

> *"There's somewhere within a five mile radius of everywhere really, isn't it? It's so easy to get hold of it, it's just having the confidence to go in and say "Look, can I have this"*
>
> Redton Girls 16+

Many, however, find this level of assertiveness hard to achieve.

Confidentiality

Confidentiality is often cited as the most important aspect of a successful young people's service. Many of the participants had very firm views about the duty of health services to provide them with confidential services. The concept of confidentiality was familiar to even the youngest participants:

> *"[The GP's] confidential, innit? They can't tell anyone else you've been there, and you've spoke about this and done like that, you know?"*
>
> Redton boys 16+

However, this understanding of confidentiality in the abstract did not always translate into confidence in services in practice.

The Family Doctor

There were some fears evident that the GP might tell parents, particularly if the same doctor treated the whole family. In this case, young people were sometimes suspicious of their doctor's ability or willingness to keep information private:

"He treats my whole family so I don't know if its confidential enough".

Blueham boys <16

"The whole family goes there as well. Like, I have got pills from the doctor, I know it is confidential and everything, but you always feel that something will get out."

Redton girls <16

In these cases, participants were doubtful about confidentiality because they suspected their parents or other relatives would discuss them with the doctor. Younger participants were more likely than older groups to distrust the practice of confidentiality.

Personal Relationships

People in the health professions have a relatively high profile in small communities, known to many people and also holding information about many. A surprising number of participants identified a personal relationship with a doctor, nurse, chemist or receptionist, either because their parents knew them, or because they themselves knew the children of the health professional. Teenagers were unclear whether professional confidentiality would extend into personal relationships:

"I couldn't trust the School Nurse because she's the mum of one of my football team."

Blueham Boys <16

"My doctor is sort of like my Dad's best mate and I'd be embarrassed like just say one night ..it slipped out."

Greyville Girls <16

Rather than fearing that a health professional would actually contact their parents and break their confidence, teenagers felt threatened by "off-duty" slip-ups within personal relationships.

Subsequent visits

In addition, some were concerned that doctors at general practices would be careless with sexual health information during future consultations that they might attend with a parent.

> *"He was going to say "Right, I can give you these antibiotics because they don't interrupt with the pill" and I'm thinking "I really just don't want my mum to know"*
>
> Redton girls 16+

> *"[Mum] came in and they took me into the examination room and he said "Oh do you take any regular medication?" And my mum was sat there, and she didn't know so I said "No" And he goes "Are you on the pill?" and I'm like "Shhhh!"*
>
> Greenham Girls 16+

Whilst they may be taking responsibility for their sexual health care alone, many of the participants still involve their parents in other aspects of their health needs. It was during these subsequent non-sexual health consultations that teenagers were afraid their parents might become privy to information that the teenagers had not wanted them to discover.

Some groups were also concerned that it was too easy to see the computer monitor showing their notes if the doctor did not take care to keep it pointed away from the patient:

> *"They've got this screen, its got all your records on it, you can see all the records. If your mum's sitting there she can see all the records."*
>
> Greenham Girls 16+

> *"It's like "Verucca, verucca, bad ear, bad foot, bad throat, morning after pill, bad throat".*
>
> Greyville Girls <16

This again might allow their parents to see confidential information.

Some participants were also concerned about maintaining confidentiality when obtaining their prescription. Any prescription which related to contraception, or indeed buying condoms or a pregnancy test at the chemist, is evidence of sexual activity:

> *"If it's a local pharmacy and people know you, like gossip can get round."*
>
> Greenham girls 16+

Although most participants were clear about what confidentiality is, and the fact that even under 16s were entitled to confidential treatment, a few raised doubts about this. In addition, there were a number of concerns that health professional's personal relationships could compromise confidentiality. There were also some specific examples given about the GP. As young people will attend their GP for general heath issues as well as sexual and reproductive health, GPs should take care not to assume it is appropriate to make reference to a teenage patient using contraception when they are accompanied by a parent. Computer screens should face the doctor and not the patient to make sure they are not over looked. This threat of breaches in confidentiality may be real or perceived, but is certainly inhibiting. It may be that health professionals and teachers should make the effort to raise and reiterate the duty of confidentiality which doctors and nurses have in relation to teenagers.

Anonymity

> *"I know it's completely confidential but like if you are under sixteen then your parents will find out any information even if you just go."*
>
> Greenham girls <16

The importance of confidentiality has been emphasised by much research about the needs of young people. For many of those in the FGDs here, however, it was not so much confidentiality as anonymity that concerned them most. Living in small towns where many people knew each other, these teenagers felt very visible, and that their actions were under scrutiny. This can make a clandestine visit to the doctor or FPC seem impossible. To quote a study on rural children[9]:

"Heightened visibility can have the effect of denying young people any privacy to conduct their lives and pursue their interests...[this] can create a particularly

claustrophobic environment for young people and have repercussions for their ability to gain confidential access to services and advice."

Most of the FGD participants did not want their parents to know if they had sexual relationships. This is why they were so concerned about issues of confidentiality and anonymity.

Being seen

Teenagers frequently expressed concerns about being seen when they were at the FPC the doctor or the chemist. They were concerned that such information would get back to their parents.

The FPC offers little chance of a visit being about something not related to sex. Where the number of FPC sessions offered is limited, there is also a high possibility of being seen at the clinic itself since all those using the FPC must attend on the same day. The girls below are discussing the weekly FP session in their local town:

"But when you walk in, the local people, there's always people in there you know, and you just sit there thinking "Oh my God!""

"I've met Emma down there so many times!"
[Laughter]

"Like one time there was me, Emma, Jackie, Michelle, Jane, and there was about six of us and we were like "hi!"(low-key embarrassed voice)..."
[Laughter]

"...Its so obvious what you're doing there."

"Jess and Becky were there on Tuesday!"

"You've got to wait in the waiting room for about half an hour. Having a little mothers meeting!"

"Its like "Why are you here?""

" But, it is confidential when you go in, but like, the fact that you're going there on the day..."

Greyville Girls 16+

Again, whilst the speakers know that the content of their consultation will be confidential, this is of limited value to them compared to their inability to seek help unnoticed by others. Although the location of this clinic has other health sessions besides being used as a FPC, attendance on a particular day makes it obvious that a sexual health issue is at stake.

Living in a small community means that either a young person's own acquaintances or those of their family pose a real threat to their privacy. By contrast, the daily FPC in Redton, was seen to offer some protection against small town "spies" as well as being discreetly marked to avoid embarrassment:

"Like outside, it's just a little plaque on the wall. It's kind of cool 'cos people don't quite realise where you're going or anything"

Greenham girls 16+

Unlike specialist services, general practices do at least offer the possibility that someone is attending for a different health problem, not necessarily to do with sex:

"If someone sees you going to the doctor then it wouldn't necessarily be like a sexual reason would it?"

Greenham girls 16+

Others felt that this security was tenuous however, as if anyone saw them and questioned what was wrong with them, the suspicions of their parents would be aroused:

"My mum always knows when I'm going to the doctor and for what reason, so if one of her friends saw me walking into the doctor's surgery and then they go "Oh what's wrong with Jenny? I saw her going into the doctor's the other day." So my mum would be like "Ooh! What's she doing I didn't know she'd been to the doctor's!"

Greenham Girls 16+

"I went to the doctor's the other night and I saw my Dad's mate and then the next day my Mum said to me "Oh, Dave saw you at the doctor's last night."

Greyville girls 16+

This kind of betrayal of anonymity is not necessarily malicious, but a concerned enquiry from a family friend is enough to cause problems for the girls concerned.

Gossip

Many of the groups described their hometown as very gossipy. It was clearly a major concern to them:

"You go in [the doctors] and you'll see loads of your friends in there and you'll think "Oh God, it's going to go all around the village, my mum's going to find out.""

Brownton/Pinkham Girls, <16

"The thing about Greenham is just everybody knows everybody and even the tiniest little piece of gossip..."

" Oh people are rotten!"

Greenham girls 16+

"I mean, this is Greyville, it might be that the doctors are not allowed to say anything, but you go in there and the next day its all round Greyville."

"Yeah, everybody knows."

"It's such a small place."

"Something happens between two people and the next day everyone knows about it...it's just like, in the air."

Greyville girls <16

Small towns, with their closely-knit communities and many threads of acquaintance, are particularly restricting for young people who feel continually observed and monitored.

Privacy vs. Accessibility

Many of the groups saw that there was a tension between wanting a service which was easily accessible to them, whilst also wishing to conduct their business privately and anonymously:

"What I think is that they should put it somewhere private."

"Well, you can't really put it in the middle of a field, can you?"

Brownton/Pinkham girls <16

"But the problem if you had [a FPC] in a small town or village is that everyone knows everyone else so just going there would be a scandal almost."

Brownton/Pinkham girls 16+

"I mean Redton, in a way is a bit far to go, maybe Limeham?"

Greenham girls 16+

The last speaker was trying to think of a town far enough away to be out of her immediate surroundings but still accessible to her. Some of the Greenham girls went to a youth club in Limeham.

Networks of Acquaintance

In many cases, participants identified a key professional, be it doctor, school or practice nurse or pharmacist, as a friend of the family or related to a friend. This was perceived to compromise anonymity and confidentiality:

"My ex-girlfriends mum works [at the FPC] ...so I wouldn't actually go there"

Blueham Boys <16

"My mum used to work at the health centre so I know all of them there."

Greyville girls <16

"Cos I know, one of my old friend's mum is one of the receptionists at Pinkham surgery and also my mum's friend is another receptionist and our old next door neighbour's a receptionist, its like a whole a whole history in, in like. I found it

really hard when I went in there to tell them why I was there, because I know them, from like three out of the four receptionists I knew."

Brownton/Pinkham Girls 16+

The complex web of acquaintance is demonstrated by this last quote. All these "friends" become perceived as a threat in the context of accessing services. It is not the confidentiality of the consultation which is a concern but the process of getting there (walking into the clinic or surgery, sitting in the waiting room or waiting at the chemist.) Underlying this is the assumption that adults *will* discuss the teenagers amongst themselves, although it is precisely such lapses in professionalism that the rules concerning confidentiality are designed to protect against.

Fear of provider attitudes

Most of the girls' FGDs revealed a concern that health professionals would look down on them, disapprove or judge them for being sexually active. This can act as a deterrent to seeking help. This is also the kind of information that friends pass on to each other about a particular service and can therefore affect more than just the individual concerned. There had been direct experience of being treated badly in some cases:

"If you've been there yourself you can understand why some people won't go..."

"I think they are judgmental. Like especially at the hospital...not necessarily at the Family Planning Clinic...."

"Yeah at the Family Planning Clinic... 'cos I've been there when I've had the morning after pill 'cos the nurse had such a go at me..."

"They give you a right lecture."

Greyville girls 16+

"Nag, nag! I don't feel comfortable with [my GP]."

Redton girls 16+

The participants were very sensitive to negative reactions form the health workers that they had encountered.

Because they were wary of being told off or disapproved of, some participants were not always honest with the health workers they saw. One group of girls in particular containing a number of participants who were experienced service users, suggested that they told health workers what they thought they wanted to hear, rather than risk censure:

"Don't you find yourself lying?...."

"Yeah."
"...and going "The condom split!"...
[laughter]

"... 'cos you can't handle the lecture that they are going to give you. And when they ask "How long have you been together" or something.."

"You lie!"

"...you lie and say "Oh, I've been with him six months" when you haven't at all."

Greyville girls 16+

If they do not get honest information from their clients, sexual health workers are unable to offer the appropriate counselling and advice about aspects such as effective contraceptive use or STI prevention. It is important that advice is given in a way that does not make teenagers feel judged.
Under 16s are particular sensitive to the reaction they may receive:

"Being under age...they really do look down on you. If you're 16 then, yeah a bit, but they do completely look down on you, if you are under age. "

Greyville girls 16+

Some of the groups were angry about such attitudes, which they considered to be out of place in a health service:

"They can't stop people having sex under age...."

" It's not their place, it's just their job...they're there to help you, they're not there to judge you and they should act like it."

Greyville girls 16+

Teenagers need services which are friendly, and where they feel able to discuss their situation honestly without feeling judged or risking a lecture. If they do not, they may not attend, or may not be open when they do see a health worker.

External barriers

The groups mentioned a number of factors relating to their ability to physically access services. As many of the participants live in rural or semi-rural locations, issues of access where particularly acute. These included:

- Location and associated transport problems
- Opening hours
- Problems with appointments
- Getting past the receptionist
- Lack of appropriate knowledge.

Location and transport

"The only trouble with my area, 'cos like I come right from that end, and it's sort of like, I can't walk up here, it's sort of like a bus journey and a train journey, then it'd be another bus journey to get up there, 'cos I won't walk, it takes too long."

Redton girls 16+

For many of the young people in the groups, specific services such as TAC and FPCs were too far away from where they lived to be a realistic service option for them. In addition, the school-based survey showed that only half of the teenagers surveyed lived in the same place as their doctor's surgery. For 18%, the GP was more than five miles away. Buses in rural areas are limited, particularly at weekends and in the evenings, both in terms of routes and their frequency. They may also be prohibitively expensive.

Walking or cycling is only an option where the services are relatively near. One girl commented of here local TAC:

> *"If I cycled there, it'd take about five hours!"*
>
> Brownton/Pinkham girls <16

Even if they are prepared to walk or cycle long distances or take public transport, this is time consuming. Most teenagers, especially younger teens, need to account for their whereabouts to their parents. Where services are located at some distance, this can be seen as problematic.

> *"But the only trouble is if like, if you are our age and you live in Brownton and there's no other places to go because you can't exactly ...get transport to anywhere like that..."*
>
> *"Yeah, and if you don't have any money and your Mum wants to know where you are going with it."*
>
> Brownton/Pinkham Girls <16

As well as often operating infrequently and being time-consuming to use, public transport also adds to the cost of a visit that this may be prohibitive for teenagers, especially those from low-income families:

> *"The bus [to Limeton] is always cheaper as well as well. Redton's about £4 return isn't it?..."*
>
> *"As long as there's somewhere nearby I'd definitely pay for the cost of it."*
>
> *"I can't afford it."*
>
> Greenham girls 16+

If services are not local, teenagers may have little idea of what is on offer, and no opportunity to investigate:

"If there was [an FPC] closer you would pop in just out of curiosity, to see whether they'd be able to help you out when you needed their help...but you wouldn't go all the way to Redton just sort of, out of curiosity."

Brownton/Pinkham girls 16+

This participant was unwilling to travel fifteen miles just to see whether or not a service might be useful to her, as a result she did not know who staffed a FPC or what services they offered.

As most of the teenagers wanted to use sexual health services without their parents knowledge, their location is an important consideration. Independent means of transport, such as walking and cycling rely on the service being reasonably close. For services further afield, buses incur extra cost and may not run at appropriate times. The length of time needed to travel may also be difficult to justify to parents. This effectively prohibits the use of some services, particularly FPCs and youth services.

Opening hours

Many teenagers have limited free time – they are at school most of the day and have obligations to be at home at other times. Older teenagers may also have evening or Saturday jobs. A number of specialist services in the district, including both TACs and some FPCs, are only open weekly. Most doctors only offer an emergency weekend service, and the Redton FPC is closed on Saturday afternoons. If there is also some distance to travel, access to specialist services can be very restricted.

"I know a friend that was working and had to get [to the FPC] in her lunch break and we were worried that we weren't going to get back in time, and she couldn't go afterwards cos she finished late, she worked late 'cos she was working, so it was kind of a bit awkward, getting the bus as well."

Greenham girls 16+

"You'd have to get the half past three [bus] wouldn't you, after school?...And your mum would be a bit wound up..."

"It closes quite early on Saturday, doesn't it."

"Yeah, Saturday morning..."

"It'd be good if it did late nights or something."

Greenham girls <16

Both these groups thought it difficult to go to their preferred sexual health provider (the Redton FPC) because of the restrictions both on their own time, and the FPC opening hours. This is despite Redton offering a daily service with some evening clinics. For those from out of town, it still does not feel readily accessible.

Where services are only open weekly, or where some sessions are staffed by nurses with limited prescribing powers, there may be even greater difficulties:

"There should be more places to get the pill on more days, 'cos you can only get it on [one day] a week...when you go down there, I said "Can I have the pill?" and they said "No, can't do it 'til Thursday" or something...."

"They should have it open more than just on the one day...'cos like everybody needs advice every day...."

"Like "OK I'll just bottle it up 'til Thursday!"

Greyville girls <16

Given the number of internal barriers many teenagers have to overcome in order to attend a service in the first place, being unable to receive the service they require when they do present themselves can be very frustrating. It may put them at further risk, or prevent them attending when they could be seen. In addition, not all participants knew the opening times of weekly services.

Problems with appointments

A few of the participants found having to make an appointment was a difficulty in itself. They were unsure what information they might have to give to the receptionist, and were worried about being able to phone in private. This was a particular concern with the doctor:

"You have to make an appointment and that, and if you was only 14 or whatever..."

"You don't have to tell them what it's about do you, when you make an appointment?"

"No, but like if you phoned from your house or something your parents might listen in and go "Ah what are you doing going to the doctor?"

Blueham boys 16+

Making an appointment may seem like an extra hurdle to overcome:

"It's like you phone up if, just say if you want to go, you usually find that they're busy and they say phone back later or something. You can't talk with them because they're always, always busy talking to other people."

Brownton girls <16

At busy times for the service, it may not be possible to make an urgent appointment at all. Where girls require EC, a quick appointment is vital.

Teenagers were also aware that they may not be able to see their own doctor in the near future:

"I wanted to go and see the doctor and I couldn't see him 'til like three weeks later."

Greyville girls <16

Given their fears about confidentiality, and how much store many put on the personality of a particular individual, teenagers may not be happy to see an available doctor who they do not know.

By contrast, where a drop-in system was available, this too could lead to problems. At busy times, a long wait was likely:

"There should be one or two more family planing clinics because, like I say, it's just too packed. I mean we were sat in there for like all day..."

"Well I've only been, used the one in Redton once, when I was 15 and I must say, I waited about an hour."

Redton girls 16+

Teenagers do not always have unlimited time to use a service, and may be put off by the inevitable waits drop-in sessions often incur.

Getting past the receptionist

As has been discussed previously, GP receptionists often expected teenagers to justify their need for an appointment while standing in a queue in the waiting room (which teenagers found both embarrassing and intrusive). Several groups reported difficulties getting an immediate appointment for EC at their doctor's, usually because receptionists wanted to know exactly why they needed a doctor urgently:

"They are really pathetic because unless you say you've been sent by the hospital or something they'll say there is like no appointments and then when you say you've been sent down by the hospital they'll say like, "How about in half an hour?"

Greenham girls <16

This girl had been already refused EC at the local casualty because her doctor's surgery was open and had to assert herself to be given an appointment with the GP.

Many felt that receptionists did not take their need seriously and did not want to be interrogated at the reception desk:

"What do you think you're having a doctor's appointment for?" ... they should be more aware, perhaps, I mean more aware that there will be people coming in [for EC]...they shouldn't ask "Well, what's wrong with you?" They shouldn't make you feel uncomfortable. So maybe they need more training or customer care, or something."

Brownton/Pinkham girls 16+

In fact, following the District wide audit of EC provision in 1997, all receptionists were sent guidelines about teenagers and emergency appointments. These guidelines recommended that all teenage girls requesting emergency appointments were assumed to be in need of EC and should be given appointments without further questioning. The experience of the participants suggest that these guidelines are not being implemented everywhere.

Lack of appropriate knowledge of services

Although focus groups are not an appropriate tool for acquiring detailed quantitative information about what the participants do or do not know, it is possible to gain an impression of the level of knowledge within the groups. Participants showed varying degrees of knowledge about the services available to them. Boys generally had poorer knowledge than the girls. As has been discussed earlier, not all the groups were familiar with what a FPC did, or the services it might offer. Others knew that an FPC was somewhere they could go, but did not know where to find their local clinic. The GUM clinic was not recognised by most of the participants. Other services, such as the TACs, were sometimes felt not to have been sufficiently publicised:

"It's got like a poster saying all the different things you can talk about..."

"Teenage, general teenage, sort of sexual, teenage things."

"It's like, you know, a drop-in thing...but I don't know how many people go, it's a bit kind of, you're not sure what's behind the door."

"They ought to publicise that more because I didn't know about that."

Greenham girls 16+

It is noticeable that one of the speakers, whilst she has seen the posters which explicitly describe the services on offer, is still unsure what to expect from the service and so is nervous of using it.

Knowledge of local services, including practical information such as where the nearest FPC is, what services it and the GP can offer, opening hours and client group need to be widely made available to young people in schools and other youth settings.

Misinformation and misconceptions

There were areas in which it became clear during the FGDs that some, or all the participants had either significant gaps in their knowledge of sexual health issues and services, or were misinformed. Misconceptions relating to specific scenarios have already been discussed (for example relating to EC) but I will look briefly at some of the

misconceptions concerning sexual activity and service use among under sixteen's and also concerning contraception and abortion.

Under sixteen's

Although most groups knew that under sixteen's could get confidential sexual health services, there were still some doubts about this among under sixteen's themselves:

> *"We're under age and that and we can't talk to anyone about it cos they'll just probably go and phone the police."*
>
> Blueham girls <16

> *"You have to be sixteen to buy [condoms]"*
>
> Brownton girls <16

> *"You've got be a certain age to see the doctor haven't you."*
>
> Greenham girls <16

The first speaker is unsure as to whether even *information* is available to her because of her age. Other people thought that under sixteen's might be prevented from purchasing condoms or from seeing their doctor. Such fears are a clear impediment to seeking help relating to sex. A general impression that under sixteen sex is "illegal", also leads the first speaker to believe that the police could be involved. In most cases, this would not be the case. It is considered statutory rape if the girl involved is twelve years old or younger. If the girl is between thirteen and fifteen, the law is also more lenient where the male partner is less than 24. Where they are unsure of their rights, the under sixteen's are unlikely to seek help. Younger teenagers need continual reassurance that they are entitled to confidential treatment and information even if they are "under-age":

> *"Just say like your boyfriend's nineteen and you're fifteen and you have sex and you fall pregnant, then he'll probably go to prison...."*

> *"But can't the bloke only get like put in prison if the parents find out?"*
>
> Greyville girls <16

Several of the under sixteen participants thought that there might be police involvement if they were sexually active.

Contraception

Throughout the discussions, various topics arose to do with contraception, abortion and services that were clearly misunderstood or misconceived by the groups. Misconceptions about EC have already been discussed. The following conversation was initially about an IUD, but considerable confusion and uncertainty about this method and the cap or diaphragm was evident. In fact the girls didn't have a clear understanding of either method and they confused which was which:

"It's like all in your ovaries."

"It's like this thing, and they shove it up and then it just like, springs open."

"So how does this stop you getting pregnant?"

"It's like a Femidom .."

"Does it cover the ovary thingies?"
"That, like the whole thing doesn't it?..."

"I though it was only a little stick thing"

"Got a little bit on the end hasn't it?"
"Well, no it's got an end and you have to go and have it checked every so often 'cos my Mum's got it..."

"What's that little round thing, the another one?"

"...And it's got like spikes on it and I thought it would hurt. But my Mum said it didn't."

"No, there's another round thing."

"Femidom?"

"The diaphragm!"

"Diaphragm, that was it."

Greyville Girls <16

There is uncertainty about which method is called a coil – here, those girls talking initially are thinking of the diaphragm, whilst a speaker in the middle describes an IUD. They don't understand how the diaphragm works, and their answers suggest that they may not have a clear understanding of female reproductive anatomy - with one girl thinking it needs to cover the ovaries to prevent pregnancy, and another questioning how this would work. Some of the participants have more of an idea about the coil, knowing that it looks like a little stick and that threads need to be checked – however, this detailed knowledge is from her mother's first hand experience. Much of their talk makes the methods sound very invasive; "they shove it up", it's "got spikes on it". There is a certain amount of scare mongering and horror stories related to the IUD. If the way in which different contraceptive methods work to prevent pregnancy is little understood, this might prevent young women from choosing methods that may in fact be suitable for their use.

Abortion

Abortion continues to be surrounded by many taboos. Not all the groups had discussed abortion in school. Those who had done so usually found that it was covered in RE lessons in the context of "moral choices". The practical details of what an abortion might involve were not clearly understood:

"We talked about abortions but no-one actually told us how it was done."

"All we got told is "Oh you go into hospital and it's all over a couple of hours, you know""

"It's not very funny but what I thought it was, I honestly thought it was some sort of injection."

"Hmmm. Well, that's what everyone thought..."
"I thought it was an injection..."

"Or a tablet sort of thing....and it just passes through or something you know what I mean?"

Redton girls 16+

Where abortion is only discussed in the context of it's moral implications, girls are left woefully ill informed about the actual procedure.

Key points

- Problems in accessing all the services providing contraception and sexual health care were described by participants. Some were to do with external barriers and some to internal barriers.
- Embarrassment was evident at all stages in getting help about sexual matters.
- Some concerns about confidentiality were raised – especially to do with subsequent visits to the doctor.
- Anonymity was a key concern when accessing services especially for those living in small towns and villages.
- Many teenagers were concerned about the attitude of service providers. This was especially true for under age sex.
- Rural children have difficulty reaching services that are not very local to them.
- Restricted opening times also affect rural teenager's ability to use services.
- Many found getting appointments quickly difficult, especially if they preferred to see a particular doctor. Conversely, drop-in sessions may involve an unacceptably long wait.
- Receptionists were often seen as a barrier to get past, especially if seeking an emergency appointment.
- Teenagers don't always have the necessary information about when and where services are. They may also be poorly informed about different types of contraception, abortion and the legal position of under sixteen sexual activity.

SOME CONCLUSIONS FROM THE FGD's

Sex education

Young people learn about sex from a variety of sources that may be more or less helpful and more or less accurate. Most picked up information from the media, from friends, from parents and from magazines. They also received some teaching at school. Despite these many sources, they were not always equipped with the facts and skills that they need in order to positively express their sexuality without risking pregnancy, STIs or exploitation. In particular, managing relationships and emotions were rarely addressed in "official" sex education.

Most participants had received sex education of some kind at school and believed that it was appropriate for schools to be involved in providing such information. However, despite feeling that they had learnt something from their lessons, and in keeping with other study findings, most were critical. They did not feel that the content addressed their needs, and in some cases it wasn't provided at a young enough age. Many wanting more details about STIs and contraception. In addition, many felt that they were not given time to explore the positive aspects of sexuality – pleasure, emotions and relationships. Boys in particular may feel excluded from sex education as it is focussed on the reproductive system of women. Discussing such issues was made more difficult if staff were embarrassed and evasive. The responses to the different scenarios described above suggest that there are important perceived deficiencies in school sex education.

Responses to the scenarios

There was a clear progression in the seriousness of situations presented in the scenarios, and this was reflected in the participants' answers. They were much more likely to think that a health professional should be involved in strictly medical and more serious situations. Thus, while almost none considered first sex, or even condom use to require a consultation with a professional, all groups thought that an STI or an unplanned pregnancy would require their help. More could be done to encourage young people to seek help before something goes wrong. As it is, many teenagers first approach the system in crisis, requiring EC or a pregnancy test (Dr Lisa Horman. Exeter FPC: personal communication) without having any previous experience of the service. Health professionals such as those at the FPC and GP need to promote themselves as a place to talk and discuss issues as well as simply providing medical interventions when things go

wrong. One group suggested that the GP could invite teenagers to consultations. (As they said "It works for the dentist" Blueham boys <16).

It was also noticeable that teenagers rarely saw their parents or their sexual partners as people to approach for information about sexual health matters. For some, even an unplanned pregnancy was something they would wish to try and deal with alone, rather than approach their parents.

The scenarios revealed gaps in teenagers' knowledge. They were not well informed about STIs and most did not know about GUM clinics. Information about how to diagnose or treat an STI was very hazy. None mentioned contact tracing and did not discuss the effect of having an STI on a relationship. Some of the groups were very well informed about EC, but others were not and many overemphasised the possibility of short and long term side effects from its use.

Teenage pregnancy was regarded by many as serious and undesirable. However, many were unprepared to consider an abortion as an option, even where the mother was young and the pregnancy unplanned. More could perhaps be done to educate young people about the reality of abortion – how common it is and how safe. Many had only addressed the issue in the context of a moral debate, which polarises the arguments very strongly. More could be done to counter what has been called the "awfulisation" of abortion[94] and to provide more accurate information to young people. Some had decided that adoption was the only acceptable answer to an unplanned pregnancy. The difficulties of carrying and then handing over a baby were under played, and none mentioned possible difficulties for the child or parents later in life. Some young women also had rather unrealistic expectations of the amount of assistance available to young mothers.

Sexual health services

Apart from those in Redton, all the FGD participants were from small rural towns and villages. This disadvantages them in a number of ways. Participants clearly felt very visible in the community. This makes it difficult to feel comfortable using local services. The fear that they might be seen by a friend or acquaintance while they were trying to get help about a sexual health matter was very strongly evident in most groups, and clearly

for many was a very real consideration when thinking about using services. This fear of being seen was usually related to their fear of parents finding out. In this sense it may be parents who are the greatest barrier to young people accessing sexual health services. However, young people also feel vulnerable to local gossip generally, and find it difficult to keep their activities private.

In addition, the services that are available to young people are often limited. Again, outside Redton, specialist FP services or those aimed primarily at young people usually operate on a weekly basis. In some cases, the service itself is also limited because they are staffed by nurses who do not have full prescribing powers. The limited number and kind of services available to young people means that they often do not have a choice about which service to use. As with other age groups, all teenagers are unlikely to want the same service.

Teenagers in rural communities often find it difficult to access services outside their immediate area because of transport difficulties. Few have access to cars of their own and cycling or walking is only an option if the distances are not too great. Buses may be infrequent and are expensive to use. In addition, young people are less likely to know about services that are not close to home. They may not have proper information about where such services are or what they offer.

Local services, including general practices are often not perceived as "teenage friendly". In particular there are major concerns over confidentiality. Getting urgent appointments (such as for EC) can be difficult.

Gender differences

Boys rarely see sexual health services as useful to them. Their requirements may be different to girls'. Boys are put off by the thought of being asked any questions by staff. Some find it difficult to deal with female staff members.

Boys were on the whole less well informed about the sexual health services available in their area, as well as seeming less inclined to use them. They had less support from their peers, and were more distrustful of revealing personal information to either friends or health care workers. Both boys' and girls' groups tended to think that boys found it harder than girls to talk about sex, or to seek help from anyone.

It was clear that boys were considered peripheral to much of the decision making about sexual health. Although they often said that it was a joint responsibility for both partners to look after contraception, for most this meant using vending machines to obtain condoms. Even in the case of an unplanned pregnancy, boys were not always seen as central to the decision making process. Not all the girls' groups considered that their partner was someone with whom a pregnant teenager would discuss her options. Many expressed concerns that a boy faced with such a situation would want nothing more to do with them (although they did think that a long-term boyfriend ought to be part of any discussions). Interestingly, beyond avenging their daughter's honour, fathers were not really involved in the process either, with most respondents turning to their mother.

When considering how a sexually active teenage boy and teenage girl might behave in relation to their sexual health the two paths are very different. From the information gleaned in these focus groups, a picture of the typical path of a teenager's sexual debut may be obtained. For girls, before embarking on a sexual relationship many will have discussed boyfriends and relationships with their female friends. The many magazines aimed at teenage girls contain factual information about contraception and sex, as well as advice about relationships, friends and boys. Although they are unlikely to consult a health professional before they embark on a sexual relationship, they may be able to get advice from a friend who has already had sex or already seen a health professional. Actual first sex is unlikely to be fully planned or anticipated and may take place after drinking. If contraception is used it is likely to be a condom. Eventually, depending on the girls, the relationship and the services available, she will go to a school nurse, youth service, FPC or GP to get EC, condoms or the pill.

By contrast, it was very noticeable in the focus group discussions how marginalised boys are in matters to do with sex and reproduction. Some are still excluded from initial discussions about puberty, and not given an equivalent session to the period talk that girls receive in Year 7. They often feel unable to speak to their friends about sex

because they are afraid of being ridiculed and teased. Few consider it appropriate to attend sexual health services. This may be for a number of reasons. They are seen as places for women, they prefer not to talk to a woman, they are wary of being interrogated by staff, they feel embarrassed, and the doctor is only seen as somewhere to go for serious illnesses or injuries. They may talk to their friends after they have had sex, but rarely in a serious way. Some feel they could discuss a serious concern in confidence with a very close friend or girl friend. If a girlfriend became pregnant, they saw the final decision about a pregnancy to rest with the girls, with only some input from themselves. Throughout the discussions, boys regarded their role as peripheral in almost all cases.

Data about teenagers' use of sexual health services in the project area.

As part of the descriptive project quantitative data was collected from the Health Authority, Family Planning Clinics and the project practices. This is presented below:

Data collected by the North and East Devon Health Authority

England sees nearly 90,000 conceptions to teenagers annually and two fifths of these end in abortion. Whilst abortion may stand as a crude indicator of the number of unwanted pregnancies, many more pregnancies will be unplanned but still lead to births. There are nearly 7,700 conceptions nationally to under 16 year olds, about half of which end in abortion (SEU, 1999). The local conception numbers and rates for conceptions to 15-17 year olds at the time of the project are as listed below in Tables 55 and 56. In North and East Devon as a whole, there are about 53 conceptions to under 16 year olds annually, giving a rate of 6.5 per 1000 girls. (In England as a whole the rate is 8.7 per 1000 girls.)

Table 55: 15-17 year old conceptions: 1992-1994

	Conceptions			
	Maternities	**Abortions**	**Total Conceptions**	**Rate per 1000 age 15-17**
N&E Devon HA	356	330	686	30.9
E. Devon CD	55	83	138	24.6
Exeter CD	106	74	180	39.4
Mid Devon	60	45	105	30.9
North Devon	68	73	141	31.8

Table 56: 15-17 year old conceptions: 1995-1997

	Conceptions			
	Maternities	**Abortions**	**Total Conceptions**	**Rate per 100 age 15-17**
N&E Devon HA	442	325	767	32.0
E. Devon CD	68	65	133	21.7
Exeter CD	145	87	232	44.0
Mid Devon	65	52	117	34.4
North Devon	98	57	155	33.5

(source: ONS 1999)

Apart from in East Devon, the rates of conception increased locally between 1992-94 and 1995-97. Apart from North Devon, much of the increase is made up of girls who chose to become mothers. This may possibly reflect an increase in pregnancies to those girls for whom teenage motherhood is accepted or desirable.

Data on teenage conceptions is available down to ward level, and this was obtained for the project areas. Table 57 below shows pregnancy rates for teenagers living in the areas served by practices that took part in this study (see chapter 2 for details of practices)

Table 57: Pregnancy Rates for Selected Local Wards in North and East Devon

Study Practice and District Council Ward	Female Population aged 13-19	All pregnancies to 13-19 year olds	
		Persons	Rate
Case 1: Blueham A	153	10	65.35*
Control 1: Blueham B	457	22	48.13*
Case 2: Greenham	503	11	21.87
Rural Greenham	469	4	8.52
Control 2: Pinkham	778	27	34.69
Outer Pinkham	191	5	26.15
Case 3: Brownton	268	9	33.57
Control 3: Mauveham	553	17	30.73
Case 4: Redton A	511	30	58.70*
Redton B	704	27	38.34
Control 4: Redton C	580	10	17.24
Case 5: Greyville west	510	23	45.08*
Greyville central	420	25	59.52*
Greyville east	345	16	46.36*
Control 5: Whiteton east	511	26	50.85*

* Indicates a rate higher than the average for the District.

Rates per 1000 women based on 1991 Census population.
Ward names have been changed to preserve anonymity.
More than one ward is listed where the practices serve large areas.
Source: N&E Devon HA 1997.

In order to preserve anonymity for the participating practices, the wards have been renamed. In some cases, outlying or adjacent wards as well as the specific ward in which the participating practices are located are also included in the table. This is because the practices draw their patients from large areas. Within North and East Devon, pregnancy rates to teenagers range from 0 to 74.87. Participating practices in the study were self-selected and as a result not all practices in wards with the highest pregnancy rates are participating, whilst some of those which are involved have lower than average pregnancy rates for the District.

Family Planning Clinic data

Exeter Family Planning Clinic is meeting increased demands, but this service alone cannot respond to all the needs of young people. Exeter is the only clinic to be open daily in the district; other services are open weekly, or less frequently. The local review of services in the region, which was published during this project's first year, has recommended that "Clinics should have open access at least once a week" (*A Strategy for Contraceptive Services in North and East Devon 1998-2000* 1998, p. 37) so these times may be subject to change in the future.

Table 58 overleaf shows the number of teenage users of East Devon Family Planning Clinics for 1st April 1997 - 31st March 1998.

Table 58: Number And Age Of Teenagers Using Exeter and East Devon Family Planning Clinics April '97-March '98

	Females			Males			
	<15	15	16-19	<15	15	16-19	Total
Exeter	136	233	2027	15	14	217	2642
Exeter College	0	0	320	0	1	21	342
East Devon College (Tiverton)	1	8	128	1	2	41	181
Cullompton	1	0	17	0	0	1	19
Okehampton	4	2	38	0	0	3	47
Sidmouth	0	0	6	1	0	2	9
Tiverton	1	6	16	0	3	4	30
Exmouth	9	12	109	0	0	7	137
Total	152	261	2661	17	20	296	3407

Data supplied by Dr Lisa Barnett at Exeter Family Planning Services

Clinic opening hours are listed below:

Exeter	Daily, Monday - Friday all day, Saturday morning
Exeter College	Weekly, Monday drop-in during term time
East Devon College	Weekly, Monday drop-in during term time
Cullompton	Bi-monthly Wednesday evenings
Okehampton	3 Thursdays and 2 Mondays a month
Sidmouth	Monthly, Tuesday afternoons
Tiverton	Bi-monthly, Monday evenings
Exmouth	Weekly, Tuesday evenings

Apart from Exeter, the numbers of under 16s seen by East Devon Family Planning Clinics is very small. Sidmouth saw just 6 teenage girls in 1997, and none of those were under 16. Sidmouth Town ward has a pregnancy rate of 15.13 and a TOP rate of 13.45 (the highest in East Devon outside Exeter) among its under 20s. (N&E Devon HA 1997). Variations in attendances may be due to a number of factors. It is possible that there may be low levels of local under age sexual activity, the opening times may be unsuitable to serve very young teenagers or teenagers may be unwilling to attend the existing services. However, most (77%) of the under 16s who use Exeter Family

Planning Clinic are from within Exeter (Dr Lisa Barnett, Family Planning Services, 1998 personal communication), as are 70% of the over 16s. Exeter FPC is apparently seeing 36.2% of 15 year old girls in Exeter and 56.3% of 16-19 year olds (1991 Census). That a third of 15 year olds have been seen by the Exeter Family Planning Clinic is a credit to its accessibility. These figures would also suggest that more than a third of 15-year-old girls in the area are sexually active. This data was obtained from Exeter Family Planning Clinics which keeps records both of the number of individuals seen by the clinic, and their postcode. To be certain of these figures one would have to confirm that the city boundaries used in the census data for Exeter and those used by the clinic are the same.

North Devon

Table 59 shows the number of consultations made by teenagers at North Devon Family Planning Clinics.

Table 59: Number Of Attendances At North Devon Family Planning Clinics January-July 1998

	Age of Attendees				Sex		Type of visit	
	<15	15	16-19	20+	Total Men*	Total Women*	Appt.s *	Drop-in*
Barnstaple Under 20s Drop-in	75	61	186	239	97	455	0	all
Barnstaple	10	41	171	675	13	861	584	276
Ilfracombe	21	33	51	135	22	207	126	88
North Devon College(Barnstaple)	0	0	270	17	44	248	0	all
Bideford	28	36	187	420	29	647	319	357
Torrington Under 20s Drop-in	13	31	25	18	16	71	0	all
Torrington	0	1	11	84	0	96	61	10
Holsworthy Under 20s Drop-in	8	4	3	0	3	12	0	all
Holsworthy	28	28	36	164	6	250	167	89

These are based on figures for the first 6 months of 1998 - the most complete records available. The figures are based on data collected for Department of Health Korner statistics that count age, sex, visits and the subject of visits. It is not possible, however, to tell from these figures the actual numbers of new users and repeat visits, the numbers of men and women in each age group, or the actual number of individuals using the services. Details from the *Contraceptive Services Strategy* document suggest that just 15 new clients were seen by the Barnstaple drop-in 1996/7 (N. & E. Devon HA 1998).
The opening times for North Devon Family Planning Clinics are shown below:

Barnstaple	Weekly, Monday afternoons, with additional sessions bi-monthly
	Weekly Thursday afternoon drop-in session for under 20s
North Devon College	Weekly Tuesday lunchtimes
Bideford	Weekly - Bimonthly Tuesday evenings, Bi-monthly Friday mornings
	Weekly Tuesday afternoon under 20s drop-in
Holsworthy	3 Monday afternoons a month
Torrington	Bimonthly Tuesday evenings
	Weekly Tuesday lunchtime drop-in
Ilfracombe	3 Tuesday evenings a month
	3 Tuesdays a month under 20s drop-in

It is interesting that the Barnstaple Under 20s drop-in is having nearly as many contacts with over 20s as with teenagers. This is due partly to those who started using the service in their teens but continue to find it convenient (North Devon Family Planning Services, personal communication). It also suggests that the drop-in in model may be seen as the most convenient for many women and not just the young. Barnstaple also sees many more under 15s at its drop-in session than appointment sessions, whilst for those aged 15 and over, numbers are not so different at appointment and drop-in sessions.

Information obtained from participating practices

Having identified the 5 pairs of practices to be used in the study, they were all asked to provide information detailing the sexual health services already offered. The questionnaire used is shown in appendix 12. Results are summarised in table 60 below:

Table 60: Sexual Health Services Already Offered By Participating Practices. (✔ = Yes. x = no)

	Case 1	Control 1	Case 2	Control 2	Case 3	Control 3	Case 4	Control 4	Case 5	Control 5
Oral Contraceptives	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Injectables	✔	✔	✔	✔	✔	✔	✔	✔	✔	x
Implants (insertion and removal)	✔	x	x	✔	✔	✔	✔	x	x	✔
IUD fitting	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Cap/diaphragm fitting	x	✔	✔	✔	✔	✔	✔	x	✔	✔
Condoms supplied	x	✔	✔	✔	x	x	x	✔	x	x
Vasectomy advice/referral	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Vasectomy performed	x	x	x	x	x	x	x	✔	x	x
Sterilisation advice/referral	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Urgent access to EC	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Advice on natural FP methods	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Counselling for unplanned pregnancy	x	✔	✔	x	✔	✔	✔	✔	✔	✔
Referral for termination of pregnancy	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Free on the spot pregnancy testing	✔	x	x	x	x	x	✔	x	x	✔
Counselling around HIV/AIDS	x	x	x	x	✔	✔	✔	✔	✔	✔
Referrals for STIs	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
Posters advertising FP service?	✔	✔	✔	✔	x	x	x	x	x	✔
Contraceptive Leaflets available in waiting area?	✔	✔	✔	✔	x	✔	✔	✔	✔	✔

As can be seen from Table 60 above, all the participating practices offered Oral Contraceptives, IUD fitting, referrals for vasectomy and sterilisation, urgent access to Emergency Contraception, termination of pregnancy referrals, and referral for sexually transmitted diseases. All but two practices were able to fit caps and diaphragms, and all but one to provide depot injectable preparations Most of the practices stated that they provided free condoms. However, in practice this may have been limited, with only certain staff having supplies, or condoms only issued in particular circumstances. Four of the ten practices did not offer fitting and removal for contraceptive implants. Most practices said they did offer counselling for unplanned pregnancy, but fewer offered counselling about HIV/AIDS. Less than half provided pregnancy testing on the spot. Although most practices said that they did display posters about Family Planning services offered and contraceptive information leaflets, these were not always visible at visits to the practices.

In addition information was obtained from the Health Authority on the number of contraceptive claims received from the trial practices in 1997; the year before the implementation phase of the project. This is shown in table 61 below.

Table 61: Contraceptive claims by age in each participating practice 1/1/97 – 31/12/97 (far right column shows percentage of registered teenage girls for whom a claim was made)

	Patient Age								
	13	**14**	**15**	**16**	**17**	**18**	**19**	**Total**	**Percent of all 13-19 girls**
Case 1	0	1	3	9	26	31	31	101	21.0
Control 1	0	2	3	9	21	32	48	115	18.4
Case 2	0	0	1	8	12	16	22	59	10.9
Control 2	0	1	2	4	6	11	13	37	7.2
Case 3	1	0	1	7	8	12	11	40	17.4
Control 3	0	1	2	9	14	14	11	51	25.7
Case 4	0	1	1	6	5	23	30	66	19.6
Control 4	0	1	2	10	8	8	10	39	12.3
Case 5	0	1	2	11	12	11	15	52	23.8
Control 5	0	2	2	10	27	27	19	87	27.1
Total	1	10	19	83	139	185	210	647	16.6

Source: NEDHA 1997

In addition, some practices also completed Contraceptive Claims forms for patients whose date of birth was not recorded.

Contraceptive claims had been made for a total of 647 teenage girls across all practices (16.6%). It can be seen that there was quite a range across practices from 7.2% - 27.1%. This almost certainly reflects the efficiency of the claims process to the Health Authority, as much as any variation in provision of contraception to teenagers.

THE DESCRIPTIVE PROJECT: SUMMARY

A range of methods were used to obtain detailed qualitative and quantitative data about the sexual health of young people in the project area. As has been mentioned before, General Practice-based drop-in clinics were seen as a possible way of increasing availability of contraceptive services to teenagers. Any health service intervention should be based on a researched "profile" of the community that the intervention is intended to benefit[95]. In the reference given this is defined as:

"A comprehensive description of the needs of a population that is defined, or defines itself, as a community, and the resources that exist within that community"

Teenagers do form a fairly well defined "community" in this sense, and the descriptive project aimed to build up as comprehensive picture as possible of their needs and resources as far as sexual health is concerned. The findings have been discussed throughout this chapter, and in general confirm firstly that General Practice is a key and (in general) trusted provider for sexual health services, and also that a drop-in clinic approach is popular and should overcome some of the barriers that young people face in accessing help. Whether this proved to be the case when exporting the pilot project model is the subject of the rest of this research study, and the findings are presented in the next chapter.

Chapter 4

Results of Drop-in Clinic Study

In this chapter I look at the findings of the drop-in clinic study. The methods used including the sample size calculation and details of the participating practices have been given in chapter 2. I start by presenting the results of the baseline survey conducted in all ten practices before the institution of the drop-in clinics. The data from the questionnaires used to measure teenage sexual health consultations during the intervention period is then presented, followed by discussion. Finally I discuss the costs and financial viability of drop-in clinic provision in primary care.

The baseline survey

Findings from the baseline survey are shown below in Tables 7-18 below. Unless stated otherwise, percentages are given as a proportion of all teenagers seen for sexual and reproductive health matters in each practice.

Table 62 shows the numbers of teenagers seen for sexual and reproductive health consultations in each practice in 1997 and the proportion of these that were under 16

Table 62: Number (% of teenage pop) Of Teenagers Seen For Sexual Health Consultations In Each Practice during 1997

	13-15	16-19	Total	%
Case 1	11	138	149	30.97
Control 1	24	148	172	27.61
Case 2	5	71	76	14.05
Control 2	7	46	53	10.37
Case 3	6	51	57	24.78
Control 3	5	66	71	35.86
Case 4	6	88	94	27.98
Control 4	6	61	67	21.27
Case 5	17	73	90	26.16
Control 5	8	113	121	37.81

Between 6.6% and 18.9% of the teenagers seen by the study practices were under 16 years of age (Mean = 10.9%).

Table 63 shows that in all practices, most of the teenagers seen were registered with their practice (range 86%-100%) with just a handful of patients seen who were not. It was

thought possible that the drop-in clinics would attract teenagers for contraceptive care who are not registered in the practice and this was monitored. Control 5 has a number of teenage girls from a local boarding school on its lists that are registered for contraceptive services only. Information on missing data is included as it may explain the low figure for registered teenagers given by Case 3.

Table 63: Number (%) Of Teenagers Seen For Sexual Health Who Were Registered With Each Practice

	Registered at this practice?		
	Yes	No	Missing data
Case 1	142 (95.3)	4 (2.7)	3 (2.0)
Control 1	166 (96.5)	1 (0.6)	5 (2.9)
Case 2	76 (100)	0 (0)	0 (0)
Control 2	48 (90.6)	0 (0)	5 (9.4)
Case 3	49 (86.0)	1 (1.8)	7 (12.2)
Control 3	66 (94.0)	0 (0)	5 (6.0)
Case 4	91 (96.8)	3 (3.2)	0 (0)
Control 4	64 (95.5)	0(0)	3 (4.5)
Case 5	88 (97.7)	0 (0)	2 (2.3)
Control 5	116 (95.9)	1 (0.8)	4 (3.3)

Practices were asked whether or not the teenagers seen in 1997 were new to sexual health services at that practice in 1997 or not. The results are shown on Table 64. Again, there was a wide range of answers; with from 19.7% to 51.3% of teenagers being seen for the first time (Mean = 35.0%).

Table 64: Number (%) Of Teenagers Attending For Sexual Health Who were new to sexual health services in 1997

	First sexual health visit in 1997?		
	Yes	No	Unsure
Case 1	45 (30.8)	97 (66.4)	5 (2.8)
Control 1	53 (30.8)	91 (54.2)	28 (15)
Case 2	29 (38.1)	41 (53.9)	6 (8.0)
Control 2	22 (41.6)	29 (54.7)	2 (3.7)
Case 3	21 (36.8)	35 (61.4)	1 (1.8)
Control 3	27 (36.7)	44 (61.9)	1 (1.4)
Case 4	23 (24.4)	71 (76.6)	0 (0)
Control 4	29 (43.2)	34 (50.7)	4 (6.1)
Case 5	48 (53.3)	42 (46.7)	0 (0)
Control 5	23 (19.0)	74 (61.1)	24 (19.9)

Table 65 below shows teenagers attending for Emergency Contraception (EC). EC accounts for a large part of some practice's contact with teenagers and very little of others. Over half of teenage girls seen had used EC at Case 2, whilst only 3% had done so in Control 4 (Mean = 20.7%). Case 2 also saw a high proportion of teenagers more than once for EC. This practice saw a relatively high proportion of teenagers for the first time for sexual health in 1997, and many of these were initially seen for EC.

In addition to the occasions on which PC4 (the commonest form of hormonal emergency contraception) was prescribed as EC, teenagers were fitted with an IUD as EC in 6 Cases (once at Control 1, once at Case 2, once at Case 5, and three times at Control 5 - two of the latter were to the same patient).

Experience at the Exeter Family Clinic suggests that presenting for EC is often the first time teenagers come into contact with sexual health services (Dr L. Barnett, personal communication). Easily accessible and well-advertised EC provision is a vital part of services for this age group.

It is also important that teenagers who are seeking EC encounter friendly and helpful services in order to encourage them to return for more appropriate long-term contraception.

Table 65: Number (%) Of Teenagers Seen For Sexual Health Who Were Prescribed Hormonal Emergency Contraception (PC4)

	Number (%) of times seen for PC4			
	Once	**Twice**	**Three times**	**Total number**
Case 1	28 (18.8)	5 (3.4)	0 (0)	33 (22.2)
Control 1	13 (7.6)	1 (0.6)	0 (0)	14 (8.2)
Case 2	21 (27.6)	2 (2.6)	4 (5.3)	27 (36.0)
Control 2	15 (10.3)	2 (1.4)	3 (2.1)	20 (13.5)
Case 3	10 (17.5)	0 (0)	0 (0)	10 (17.5)
Control 3	10 (12.2)	1 (1.2)	2 (2.4)	13 (15.8)
Case 4	7 (7.4)	2 (2.1)	0 (0)	9 (9.5)
Control 4	2 (3.0)	0 (0)	0 (0)	2 (3.0)
Case 5	26 (28.9)	0 (0)	0 (0)	26 (28.9)
Control 5	23 (19.0)	4 (3.3)	0 (0)	27 (22.3)

In all the practices, teenagers receiving contraception were almost all using the combined oral contraceptive (COC) pill. (Table 66 below). The practice with the highest figure for COC use, Control 2, seems to offer a limited method mix as it had not provided teenagers with any other type of contraception in the study year. The proportion of teenagers using COC ranged from 50.9% to 83.7% (Mean = 70.9%) of those receiving any sexual health care.

Department of Health figures from first contacts at Family Planning Clinics during 1996/7 show that 41% of under 16s and 55% of 16-19 year olds chose COC as their method of contraception[96] The figures in the project sample are higher. The low level of condom provision may explain this. The same source shows condoms as the main method for 50% of under 16s and 33% of 16-19 year olds.

The Depo-Provera injectable was the next most popular contraceptive after COC, being chosen by up to 11.1% of teenagers. No teenagers were using the cap or Norplant, and few chose the Intra Uterine Device (IUD), or the Progestogen only pill (POP). Condoms were only supplied by some of the practices, and then only to a few patients. The "Condoms - Supp" column shows those who were given condoms as protection against STIs, whilst using another main form of contraception.

Table 66: Number (%) Of Teenagers Receiving Sexual Health Care Who Were Prescribed Each Type Of Contraception

	COC	POP	Condoms	Condoms (supp)	Depo-Provera	Norplant	Cap	IUD
Case 1	115 (77.2)	0 (0)	0 (0)	3 (2.0)	10 (6.7)	0 (0)	0 (0)	2 (1.3)
Control 1	127 (73.8)	3 (1.7)	1 (0.6)	1 (0.6)	5 (2.9)	0 (0)	0 (0)	1 (0.6)
Case 2	34 (81.0)	0 (0)	1 (2.4)	2 (4.8)	0 (0)	0 (0)	0 (0)	0 (0)
Control 2	41 (83.7)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)
Case 3	29 (50.9)	0 (0)	0 (0)	1 (1.8)	2 (3.5)	0 (0)	0 (0)	0 (0)
Control 3	57 (72.2)	1 (1.3)	1 (1.3)	0 (0)	5 (6.3)	0 (0)	0 (0)	1 (1.3)
Case 4	73 (77.7)	9 (9.6)	5 (5.3)	9 (9.6)	9 (9.6)	0 (0)	0 (0)	0 (0)
Control 4	42 (62.5)	1 (1.5)	0 (0)	0 (0)	3 (4.5)	0 (0)	0 (0)	0 (0)
Case 5	60 (66.7)	2 (2.2)	2 (2.2)	7 (7.8)	10 (11.1)	0 (0)	0 (0)	2 (2.2)
Control 5	85 (70.2)	3 (2.5)	1 (0.8)	0 (0)	11 (9.1)	0 (0)	0 (0)	0

Information from the South Molton pilot project suggested that a number of practical problems can arise for those teenagers using the COC. Side effects are relatively common, and are often perceived as being related to the particular brand of pill being prescribed. How effectively such problems are dealt with (for example by a change in type of COC) may influence the acceptability of General-Practice based services for teenagers. A question was therefore included about change in pill brand during the year. Results are shown in table 67 below. An alternative brand was tried during the year in between 4.9% and 27.6% of cases (mean = 13.2%). Between 0 and 5.2% (mean = 1.5%) of the teenagers tried an alternative brand more than once.

Table 67: Number (%) Of Teenagers Attending For Sexual Health Who Changed Pill Brand During The Year

	Changed once	Changed more than once
Case 1	18 (15.6)	2 (1.7)
Control 1	18 (13.8)	0 (0)
Case 2	4 (11.8)	0 (0)
Control 2	2 (4.9)	0 (0)
Case 3	8 (27.6)	1 (3.4)
Control 3	9 (15.5)	3 (3.4)
Case 4	6 (8.2)	1 (1.4)
Control 4	6 (13.9)	1 (2.4)
Case 5	6 (9.7)	0 (0)
Control 5	5 (5.7)	1 (1.1)

Percentages are expressed as a proportion of the total number of COC and PO pill users in each practice

Table 68 below shows the number of pregnancy tests that were performed for teenagers in each practice. Some practices had "on the spot" testing kits, but others had to send test samples to a local laboratory (with results taking up to 48 hours to be available). Six of the practices did not perform any on the spot pregnancy tests, whilst one, Control 3 provided twice as many on the spot tests as those which had to be sent away for results. This practice had the highest proportion of teenagers seen for a pregnancy test. The

proportion of teenagers who presented for a pregnancy test varied from 2.1% in Control 2 to 33.4% in Control 3.

Table 68: Number (%) Of Teenagers Having Pregnancy Tests At Each Practice (and number of tests per patient)

	Number (%) of tests (sent away)			Number (%) (done on the spot)			
	1	2	3+	1	2	3	Total
Case 1	20 (13.4)	2 (1.3)	1 (0.7)	2 (1.4)	0 (0)	0 (0)	25 (16.8)
Control 1	24 (14.0)	2 (1.2)	0 (0)	0 (0)	0 (0)	0 (0)	26 (15.2)
Case 2	4 (9.5)	0 (0)	1 (2.4)	0 (0)	0 (0)	0 (0)	5 (9.5)
Control 2	2 (1.4)	1 (0.7)	0 (0)	0 (0)	0 (0)	0 (0)	3 (2.1)
Case 3	3 (5.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	3 (5.3)
Control 3	4 (4.8)	0 (0)	0 (0)	9 (10.8)	1 (1.3)	1 (1.3)	15 (33.4)
Case 4	7 (7.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	7 (7.4)
Control 4	7 (10.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	7 (10.4)
Case 5	8 (8.9)	0 (0)	0 (0)	5 (5.6)	0 (0)	0 (0)	13 (14.5
Control 5	9 (7.4)	2 (1.7)	1 (0.8)	10 (8.3)	2 (1.7)	0 (0)	24 (19.9)

Table 69 below shows the number of pregnancies among teenagers at each practice and their outcomes during 1997. Additional pregnancy outcomes occurring in 1998 (i.e. after the data collection year of 1997) are not listed. One practice, Case 2, had no teenage pregnancies during 1997. Pregnancies occurred in other practices in between 1.4% and 9.3% of teenagers attending for sexual health, and these resulted in between 1.1% and 5.8% having a baby and 1.1% to 3.4% having a termination.

Table 69: Number (%) Of Pregnancies Among Teenagers Attending For Sexual Health In Each Practice And Their Outcomes

	Pregnancies	Births	TOP	Miscarriages
Case 1	13 (8.8)	8 (5.4)	5 (3.4)	0 (0)
Control 1	16 (9.3)	10 (5.8)	5 (2.9)	1 (0.6)
Case 2	0 (0)	0 (0)	0 (0)	0 (0)
Control 2	2 (1.4)	2 (1.4)	0 (0)	0 (0)
Case 3	2 (3.6)	1 (1.8)	1 (1.8)	0 (0)
Control 3	4 (4.8)	4 (4.8)	0 (0)	0 (0)
Case 4	3 (3.2)	1 (1.0)	2 (2.1)	0 (0)
Control 4	5 (7.5)	4 (6.0)	1 (1.5)	0 (0)
Case 5	2 (2.2)	1 (1.1)	1 (1.1)	0 (0)
Control 5	7 (5.9)	3 (2.5)	2 (1.7)	2 (1.7)

Table 70 overleaf shows the numbers of teenagers who had a cervical smear in each of the study practices. Current guidelines advise that smears are unnecessary in the under 20s. These practices show that between 7.8% and 24.4% of under 20s are given a smear test and that a small proportion do receive Borderline/mild results or Moderate/severe result

Table 70: Number (%) Of Teenagers Seen For Sexual Health Who Had A Smear At Each Practice

		Initial smear result					Repeat smear result			
	Smear taken	Normal	Inadequate	Borderline/ mild	Moderate/ severe	Repeat smear taken	Normal	Inadequate	Borderline/ mild	Moderate/ severe
Case 1	24 (16.2)	16 (10.7)	1 (0.7)	7 (4.7)	0 (0)	2 (1.3)	0 (0)	0 (0)	1 (0.7)	1 (0.7)
Control 1	24 (14.0)	20 (11.6)	1 (0.6)	3 (1.7)	0 (0)	3 (1.7)	2 (1.1)	1 (0.6)	0 (0)	0 (0)
Case 2	0 (0)	-	-	-	-	0 (0)	-	-	-	-
Control 2	5 (9.4)	5 (9.4)	0 (0)	0	0 (0)	0 (0)	-	-	-	-
Case 3	5 (8.8)	4 (7.0)	0 (0)	1 (1.8)	0 (0)	0 (0)	-	-	-	-
Control 3	20 (24.4)	15 (21.1)	0 (0)	3 (3.6)	2 (2.4)	2 (2.4)	1 (1.2)	0 (0)	1 (1.2)	0 (0)
Case 4	5 (5.3)	5 (5.3)	0 (0)	0 (0)	0 (0)	0 (0)	-	-	-	-
Control 4	6 (9.1)	4 (6.0)	0 (0)	2 (3.0)	0 (0)	2 (3.0)	0 (0)	0 (0)	2 (3.0)	0 (0)
Case 5	7 (7.8)	7 (7.8)	0 (0)	0	0 (0)	0 (0)	-	-	-	-
Control 5	13 (10.7)	10 (8.3)	0 (0)	3 (2.5)	0 (0)	3 (8.3)	2 (1.6)	0 (0)	1 (0.8)	0 (0)

Table 71 shows the proportion of teenagers attending each practice for sexual health consultations who received swabs or other tests for STI's in 1997. There is again a wide range in the figures with just 2.4% having a swab in Case 2, compared to a fifth (20.3%) in Case 1. Table 72 shows the numbers of positive results in each practice. Here it can be seen that more swabs do not always detect more infections - Case 1 does not have the highest proportion of infections detected despite taking the most samples. This may suggest that a greater targeting of teenagers at risk may be required.

Table 71: Number (%) Of Vaginal Swabs Taken Among Teenagers

	Number of swabs taken				
	1	2	3	4	Total
Case 1	18 (12.2)	8 (5.4)	4 (2.7)	0 (0)	30 (20.3)
Control 1	10 (5.8)	0 (0)	0 (0)	0 (0)	10 (5.8)
Case 2	0 (0)	1 (2.4)	0 (0)	0 (0)	1 (2.4)
Control 2	1 (1.9)	0 (0)	1 (1.9)	1 (1.9)	3 (5.7)
Case 3	4 (7.0)	1 (1.8)	0 (0)	0 (0)	5 (8.8)
Control 3	8 (9.8)	2 (2.4)	2 (2.4)	0 (0)	12 (14.6)
Case 4	6 (6.3)	1 (1.0)	0 (0)	0 (0)	7 (7.4)
Control 4	7 (10.8)	3 (4.6)	0 (0)	0 (0)	10 (15.4)
Case 5	7 (7.8)	2 (2.2)	1 (1.1)	0 (0)	10 (11.1)
Control 5	14 (11.7)	2 (1.7)	0 (0)	1 (0.8)	17 (14.2)

Table 72: Number (%) Of Teenagers Who Received Positive Swab Results

	Chlamydia	Viral infection	Bacterial infection	PID	Other positive result	Total No. (%) of positive results
Case 1	2 (1.3)	3 (2.0)	8 (5.4)	0 (0)	4 (2.7)	17 (11.4)
Control 1	1 (0.6)	10 (5.8)	3 (1.7)	0 (0)	6 (3.5)	20 (11.6)
Case 2	0 (0)	0 (0)	1 (2.4)	0 (0)	0 (0)	1 (2.4)
Control 2	1 (1.9)	0 (0)	2 (3.8)	0 (0)	1 (1.9)	4 (7.6)
Case 3	0 (0)	0 (0)	2 (3.5)	0 (0)	0 (0)	2 (3.5)
Control 3	1 (1.2)	1 (1.2)	2 (2.4)	0 (0)	0 (0)	0 (0)
Case 4	1 (1.5)	0 (0)	2 (2)	0 (0)	0 (0)	3 (3.2)
Control 4	1 (1.5)	0 (0)	0 (0)	0 (0)	7 (10.4)	8 (11.9)
Case 5	0 (0)	0 (0)	6 (6.7)	0 (0)	0	6 (6.7)
Control 5	4 (3.3)	3 (2.5)	4 (3.3)	1 (0.8)	6 (5.0)	18 (14.9)
Total	11	17	30	1	24	81

Table 73 below shows the number of teenagers who were referred to other agencies by their GP for sexual and reproductive health problems. Teenagers were most likely to be referred to a gynaecologist - usually because of a pregnancy. Teenagers were also referred to GUM clinics, to counsellors and to a Family Planning Clinic. One practice, Case 5, had referred 10% of those it was in contact with to the Family Planning Clinic.

Table 73: Number (%) Of Teenagers Attending For Sexual Health Referred To Other Agencies

	Agency referred to				
	Counsellor	GUM	FPC	Gynaecologist	Other
Case 1	1 (0.7)	4 (2.7)	0	9 (6.1)	0
Control 1	2 (1.2)	3 (1.8)	2 (1.2)	8 (4.7)	2 (1.2)
Case 2	1 (2.5)	1 (2.5)	1 (2.5)	0	2 (5.0)
Control 2	2 (3.8)	0	1 (1.9)	2 (3.8)	1 (1.9)
Case 3	0	0	0	2 (3.5)	0
Control 3	2 (2.4)	2 (2.4)	1 (1.2)	6 (7.2)	0
Case 4	1 (1.0)	2 (2.1)	3 (3.1)	3 (3.2)	0
Control 4	1 (1.5)	2 (3.0)	0	2 (3.0)	1 (1.5)
Case 5	0	0	9 (10.0)	1 (1.1)	0
Control 5	7 (5.8)	5 (4.1)	0	7 (5.8)	8 (6.6)

The baseline survey provided the data on consultation rates against which the success of the drop-in clinics could be determined. It demonstrated that case and control practices were reasonably well matched regarding their provision for teenagers sexual health needs.

Drop-in Study Results

The five drop-in clinics in "case" practices opened in mid 1998 and closed at the end of 1999. As described in chapter 2, special forms were completed by both case and control practices during the intervention period (appendices 8 and 9). These recorded details of all teenagers attending for any sort of sexual health consultation. These results were compared with those for 1997 obtained in the baseline survey .In order to make a direct

comparison, the complete year 1999 was compared to 1997. These results are presented in table 74 below.

However the main outcome measure for the intervention was an increase in the proportion of teenage girls attending for contraception (including emergency contraception). These data are presented in table 75 below.

In addition, the TAC clinics kept records of all teenagers attending for any reason. These results are presented and discussed later in the chapter.

The study practices varied considerably in the percentage of teenagers they saw for sexual health matters, from 10.4% to 37.8% in 1997 and 10.5% to 45.6% in 1999 (table 74). However, pairs of practices saw similar percentages of teenage girls and overall, case practices saw 29.1% of their teenagers in 1997 and control practices saw 24.6%. In 1999, case practices saw a mean of 26.5% of their teenage girls for sexual health matters and control practices saw 21.7%.

Table 74: Teenage girls' sexual health consultations in normal general practice and TAC in 1997 and 1999

	1997				1999						
	13-15	16-19	13-19	%	13-15	16-19	13-19	%	Change	Significance	95% CI
Case 1	11	138	149	30.97	12	151	163	33.26	+2.29	p=0.445	-3.59 to +8.15
Control 1	24	148	172	27.61	18	195	213	32.42	+4.81	p=0.061	-0.22 to +9.81
Case 2	5	71	76	14.05	17	64	82	13.92	-0.13	p=0.951	-4.22 to +3.92
Control 2	7	46	53	10.37	11	50	61	10.53	+0.16	p=0.930	-3.55 to +3.81
Case 3	6	51	57	24.78	12	63	75	29.76	+4.98	p=0.221	-3.02 to +12.87
Control 3	5	66	71	35.86	6	31	37	18.14	-17.72	p<0.0001	-26.20 to –9.12
Case 4	6	88	94	27.98	3	75	78	18.10	-9.88	p=0.001	-16.00 to –3.90
Control 4	6	61	67	21.27	3	53	56	16.87	-4.40	p=0.154	-10.51 to 1.66
Case 5	17	73	90	26.16	13	151	164	45.56	+19.39	p<0.0001	+12.40 to + 26.2
Control 5	8	113	121	37.81	14	73	87	26.85	-10.96	p=0.003	-18.09 to – 3.74
All cases	45	421	466	29.12	57	504	562	26.48	+2.36	p=0.084	-0.32 to +5.04
All Cont	50	434	484	24.61	52	402	454	21.66	-2.95	p=0.026	-5.54 to 0.35

Table 75: 13-19 year old girls seen at practices for contraception (including Emergency contraception) in 1997 and 1999

		1997			1999				
	Teens Seen	Teens	% seen	Teens Seen	Teens	% seen	Change	Significance	95% CI
Case 1	137	481	28.48	151	490	30.82	+ 2.33	p = 0.426	- 3.42 to +
Control 1	137	623	21.99	179	657	27.24	+ 5.25	p = 0.029	+ 0.53 to +
Case 2	67	541	12.38	77	589	13.07	+ 0.69	p = 0.729	- 3.25 to +
Control 2	45	511	8.81	56	579	9.67	+ 0.87	p = 0.623	- 2.64 to +
Case 3	36	230	15.65	69	252	27.38	+ 11.73	p = 0.002	+ 4.41 to +
Control 3	69	198	34.85	34	204	16.67	- 18.18	p = <0.0001	- 26.52 to -
Case 4	87	336	25.89	66	431	15.31	- 10.58	p = 0.0003	- 16.45 to -
Control 4	46	315	14.60	50	332	15.06	+ 0.46	p = 0.870	- 5.09 to +
Case 5	89	344	25.87	137	360	38.05	+ 12.18	p = 0.0005	+ 5.31 to +
Control 5	108	320	33.75	66	324	20.37	- 13.38	p = 0.0001	- 20.14 to -
All Cases	416	1932	21.53	500	2122	23.56	+ 2.03	p = 0.123	- 0.55 to +
All Cont	405	1967	20.59	385	2096	18.37	- 2.22	p = 0.074	- 4.66 to +

1999 figures includes girls seen at the TACs.
Registered girls

	1997	1999
Mean	389.9	421.8
SD	140.6	152.9

Table 75 shows for each case/control practice, and for cases combined and controls combined, the numbers, percentages and percentage change for visits for contraception for teenage girls between 1997 (prior to the intervention) and 1999 (during the intervention). The percentages are calculated to the base of all registered teenage girls.

In 1999, case practices saw a mean of 23.56% of their registered teenage girls for contraception, and control practices saw a mean of 18.37% (Table1). This is similar to the mean for all practices in North and East Devon in that year, of 19.37% (range 2.59%-36.74%).

The Mantel-Haenszel chi-square was used to assess whether there was a significant relationship between cases and controls in numbers seen for contraception in 1997 and 1999. The relationship was significant ($\chi^2 = 6.47$, $p = 0.011$). There were more visits for contraception in case practices. However, using the chi-square test to assess relationships in each pair separately, only for pairs 3 and 5 were the relationships significant ($\chi^2 = 20.96$, $p = 0.0001$; $\chi^2 = 19.35$, $P < 0.0001$, respectively). Thus, although there is a statistically significant difference between cases and controls for contraceptive visits, the expected ten-percentage point increase in sexual health consultations for cases as a result of the TACs was not achieved.

Between 1997 and 1999, visits for contraception in the case practices increased by 2.03% in contrast to visits in control practices which decreased by 2.22% (types of contraception provided are shown in table 76 overleaf). Thus the intervention failed to meet its target of a ten-percentage point increase in visits for contraception in case practices.

Attendance overall in 1999, at an increase of 2.03%, was less than expected. This suggests that the pilot model is not readily imported into all general practices. Other local factors are likely to be responsible for successful implementation. Possible reasons for this will be discussed later in this chapter.

Table 76: Number (%) of Teenagers receiving sexual health care who were prescribed each type of contraception in 1999 and 1997

	1997						1999					
	COC	POP	Condoms	Condoms (supp)	Depo-Provera	IUD	COC	POP	Condoms	Condoms (supp)	Depo-Provera	IUD
Case 1	115 (77.2)	0 (0)	0 (0)	3 (2.0)	10 (6.7)	2 (1.3)	123 (75.9)	1 (0.6)	5 (3.1)	2 (1.2)	13 (8.0)	0 (0)
Control 1	127 (73.8)	3	1 (0.6)	1 (0.6)	5 (2.9)	1 (0.6)	146 (68.5)	7 (3.3)	1 (0.5)	0 (0)	14 (6.6)	2 (0.9)
Case 2	64 (84.2)	0 (0)	1 (1.3)	2 (2.6)	0 (0)	0 (0)	55 (78.6)	1 (1.4)	0 (0)	4 (5.7)	4 (5.7)	0 (0)
Control 2	41 (83.7)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	47 (77.0)	2 (3.3)	0 (0)	1(1.6)	3(4.9)	0 (0)
Case 3	29 (50.9)	0 (0)	0 (0)	1 (1.8)	2 (3.5)	0 (0)	48 (67.6)	1 (1.4)	3 (4.2)	1 (1.4)	5 (7.0)	0 (0)
Control 3	57 (72.2)	1	1 (1.3)	0 (0)	5 (6.3)	1 (1.3)	22 (59.5)	0 (0)	1 (2.7)	0 (0)	5 (13.5)	0 (0)
Case 4	73 (77.7)	9	5 (5.3)	9 (9.6)	9 (9.6)	0 (0)	41 (53.2)	6 (7.8)	7 (9.1)	1 (1.3)	8 (10.4)	1(1.3)
Control 4	42 (62.5)	1	0 (0)	0 (0)	3 (4.5)	0 (0)	44 (78.6)	1 (1.8)	0 (0)	2 (3.6)	4 (7.1)	1 (1.8)
Case 5	60 (66.7)	2	2 (2.2)	7 (7.8)	10 (11.1)	2 (2.2)	92 (67.6)	2 (1.5)	2 (1.5)	4 (2.9)	13 (9.6)	0 (0)
Control 5	85 (70.2)	3	1 (0.8)	0 (0)	11 (9.1)	0 (0)	40 (46.0)	2 (2.3)	1 (1.1)	0 (0)	14 (16.1)	2 (2.3)

1997 COC Case Mean = 73.2% Control Mean = 72.7%
Depo Case Mean = 6.6% Control Mean = 5.0%

1999 COC Case Mean = 63.9% Control Mean = 65.9%
Depo Case Mean = 7.7% Control Mean = 8.8%

None of the practices prescribed implants or the cap or diaphragm to teenagers in either year

COC= Combined Oral Contraceptive

POP= Progestogen Only Pill

TAC clinic consultations

Table 77 below shows the numbers attending the clinics during the entire eighteen months of the study.

Table 77: Number of consultations at TAC

	Teenagers	Consultations
Case 1	8	8
Case 2	15	22
Case 3	8	26
Case4	1	4
Case 5	45	79
Total	77	139

The Teenage Advice Clinics had varied success at attracting teenagers to their services, but only case 5 attracted reasonable numbers. This was clearly a very disappointing result given the apparent success of the pilot project and our attempts to reproduce as far as possible the methods used. We decided to extend the running time of the drop-in study from 12 to 18 months to try and attract more teenagers. However, attendance remained low apart from in Case 5 and unfortunately for logistic reasons we were unable to extend the running time of the study any further. I will discuss the failure of the drop-ins to reproduce the success of the S Molton pilot scheme in detail later. There were however some encouragement's on detailed analysis of the TAC clinic data. Further details of the TAC localities and of those using TAC, together with first visit outcomes are shown below:

Case 1 (see table 78 overleaf)

TAC consultations

Case 1 saw 8 teenage clients for 8 visits, 6 had been somewhere else for sexual health before (In addition, 15 older women dropped in)

Condoms supplied on 0 occasions.

COC supplied on 7 occasions.

Depo provided on 1 occasion.

EC on 1 occasion.

1 negative pregnancy tests.

Table 78 details of case 1 clients (SHR = sexual health related)

	Age	No visits	Previous SHR consultation?	Cont. at first visit	First visit outcome
1	18	1	None	None	COC
2	19	1	GP	COC	COC
3	17	1	GP	COC	COC
4	19	1	GP	COC	COC
5	18	1	None	Condom	P/T –ve, COC
6	16	1	None	Condom	EC, COC
7	18	1	GP	COC	Depo
8	18	1	GP	Condom	COC

All but one of these teenagers were already using contraception, including 4 who were already on the pill, at the time of their first visit

A number were referred to the service from the Health Centre, which may account for the high number of over 20s using the service.

The drop-in seems to be used as a one off emergency rather than an on-going service.

None of the attendees were under 16 years of age.

All were continued or were moved onto hormonal contraception.

2 came in crisis - 1 x EC, 1 x Pregnancy Test (Neg.)

Case 2 (see table 79)

TAC Consultations

Case 2 saw 15 clients for 22 visits, 9 had not been seen anywhere before.

Condoms supplied on 12 occasions.

COC supplied on 6 occasions.

Depo provided on 2 occasions.

EC on 1 occasion.

4 negative pregnancy tests.

3 X Norithesterone to a group of girls who all came together wishing to delay menses during a school trip.

Table 79 details of case 2 clients

	Age	No visits	Previous SHR consultation?	Cont. at first visit	First visit outcome
1	17	1	None	None	-ve P/T Condoms
2	18	1	None	Condom	COC
3	15	1	None	None	Norethisterone to delay menses on school trip.
4	14	1	None	None	Norethisterone to delay menses on school trip.
5	17	6	None	Condom	Advice re COC and Crohn's disease. Condoms
6	14	1	None	None	Advice - came for norithesterone. Not needed
7	14	1	None	None	Norethisterone to delay menses on school trip.
8	15	1	A&E	Condom	COC
9	16	2	FPC	Condom	Depo
10	16	1	FPC	COC	COC + condoms
11	19	1	GP	Depo	-ve PT, condoms
12	16	1	None	Condom	Condom (male)
13	16	1	FPC	Condom	Info. On Depo
14	15	1	None	Condom	COC
15	15	2	School nurse	Condom	-ve PT. Condoms

The clients have mostly been moved on to more reliable forms of contraception ,one was using nothing and was supplied with condoms. Two using condoms have been supplied with COC

One using condoms has been given Depo.

3 attended first in crisis - all needed a pregnancy tests, all were negative.

All but one of the clients was female.

Five clients were under 16 at the time of their first visit.

Three were not registered at the practice.

Two were accompanied by the school nurse, 3 with friends, one with a parent and the rest alone.

Fourteen were at school, one away at University but home for the holidays.

Two were smokers.

Three had menstrual problems - one amenorrhoea due to Depo, two had irregular cycles and one of these also had very heavy periods.

Only one was not happy for their GP to be informed.

Of those who came more than once to TAC, none saw an alternative provider.

CASE 3 (see table 80)

TAC Consultations

Case 3 saw 8 clients for 26 visits, 6 had not been seen anywhere before.

Condoms supplied on 16 occasions (9 in addition to COC).

COC supplied on 13 occasions.

Depo provided on 0 occasions.

EC on 3 occasions.

3 negative pregnancy tests.

1 swab taken - results negative (to male client)

Table 80: details of case 3 clients

	Age	No visits	Previous SHR consultation?	Cont. at first visit	First visit outcome
1	14	7	None	Condom	EC.
2	14	3	None	Condom	Condoms
3	16	7	None	None	-ve PT, condoms
4	17	2	None	Condom	COC
5	14	2	GP	None	-ve PT, COC
6	15	1	None	None	(Male) Bloods & swabs taken
7	16	3	None	None	-ve PT, COC + condoms
8	16	1	GP	Condom	EC, condoms

All were at school. Four attended alone, the rest were accompanied by a friend for at least some of their consultations.

6 attended in crisis - 2 x EC, 3 x Pregnancy Test (all negative).

4 were under 16 at their first visit.

One client was male.

Four were not using any contraception at their first visit. Two were initially given condoms (1 with COC), and two COC alone. Two later also moved to COC.

Two had painful periods.

Three did not want their GP to know about the visit.

Two also saw their GP whilst using TAC.

One telephone enquiry was made by the mother of a teenage boy about condom use.

CASE 4

TAC Consultations

Case 4 has seen 1 client for 4 visits. She had previously seen a school nurse.

Condoms supplied on 1 occasion.

3 negative pregnancy tests, 1 positive.

Two referred to the GP.

Table 81: details of case 4 clients

	Age	No visits	Previous SHR consultation?	Cont. at first visit	First visit outcome
1	19	4	School nurse	Condom	-ve PT

This girl was on a training course, using condoms but erratically. Had previously seen the college nurse for condoms and complained of amenorrhoea.

She was referred to the GP for further contraceptive consultation but continued to use condoms sporadically. Now pregnant and referred to GP for termination.

CASE 5 (see table 82 overleaf)

TAC Consultations

Case 5 saw 45 clients for 79 visits, 10 clients had definitely not been seen anywhere before.

Condoms supplied on 28 occasions, COC supplied on 35 occasions, Depo provided on 16 occasions. EC supplied on 8 occasions.

15 negative pregnancy tests, two positive pregnancy tests.

One client was male - all the rest were single females.

Most (n=24) were living at home with one or both parents, 2 lived alone, 4 with a partner and 1 with friends. Data for 10 clients is missing.

17 are at school or college, 9 are employed and 5 unemployed.

20 are known to smoke.

When they first came to the TAC, 15 were already using condoms, and 9 the pill. 11 weren't using any regular contraception at their first visit

10 had had unprotected sex and needed EC at their first visit,

6 clients had babies and one had previously had a TOP.

Only 1 preferred that her GP was not informed.

2 of those returning to TAC also consulted another health professional

Table 82: details of case 5 clients

	Age	No visits	Previous SHR consultation?	Cont. at first visit	First visit outcome
1	15	3	None	Condom	Depo
2	16	1	GP - FP session	COC	Depo
3	16	1	GP	None	P/T –ve
4	18	1	None	Condom	Depo
5	18	3	GP- FP session	COC	COC
6	17	3	GP- FP session	None	Pre-conception counselling. Folic acid
7	14	2	None	None	COC + condoms
8	14	2	GP- FP session	None	Failed EC IUD fit. –ve P/T. Condoms
9	19	2	?	None	EC
10	15	2	GP- FP session	Condom	EC
11	17	2	GP- FP session	COC	COC
12	18	1	GP- FP session	COC	COC + condoms
13	18	1	GP- FP session	Condom	Depo
14	19	1	GP GP- FP session	Condom	P/T –ve. EC. Condoms
15	?	1	GP GP- FP session	None	Depo (post partum)
16	17	3	GP- FP session	COC	COC, condoms
17	17	2	?	?	Swab. Candida treated.
18	19	1	GP- FP session	None	Depo (post partum)
19	14	1	GP	?COC	Depo
20	17	1	GP- FP session	COC	P/T negative
21	16	3	?	Condom	P/T – ve, COC + condoms
22	16	1	?	None	P/T +ve. Refer to GP
23	16	1	GP- FP session	COC	COC
24	15	3	GP- FP session	None	P/T –ve. Depo
25	16	1	None	None	P/T –ve. COC + condoms
26	18	1	GP	COC	COC + condoms
27	17	3	GP- FP session	Condom	P/T –ve, condoms
28	15	2	?	?	P/T –ve, condoms
29	16	1	None	Condom	(Male.) Condoms
30	16	6	GP- FP session	None	P/T –ve, EC, COC + condoms
31	15	1	None	Condom	EC, condoms
32	19	2	GP	Condom	COC
33	18	6	GP- FP session	Condom	Counselled re Depo – to return.
34	19	1	GP- FP session	POP	Condom
35	17	1	None	None	COC
36	19	2	None	Condom	Condom
37	17	1	GP- FP session	COC	COC. Treated for candida
38	17	2	None	Condom	COC
39	19	1	GP- FP session	COC	COC
40	15	1	GP- FP session	COC	COC
41	16	1	GP	None	EC, COC + condoms
42	19	1	GP	Condom	-ve PT, Depo
43	17	1	FPC	None	-ve PT, COC + condoms
44	16	1	None	Condom	COC + condoms
45	16	1	None	Condom	EC, condoms

Further analysis of TAC attendees

Most of those coming to TAC were teenage girls, although Case 5 and Case 2 each saw one 16 year old boy, and Case 3 one 15 year old boy (table 83).

Table 83: Age of TAC attendees

	Case 1		Case 2		Case 3		Case 4		Case 5	
Age	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
14	0	0.0	3	20.0	2	25.0	0	0.0	0	0
15	0	0.0	4	26.7	2	25.0	0	0.0	9	20.0
16	1	12.5	4	26.7	3	37.5	0	0.0	10	23.3
17	1	12.5	2	13.3	1	12.5	0	0.0	9	20.9
18	4	50.0	1	6.7	0	0.0	0	0.0	7	16.3
19	2	25.0	1	6.7	0	0.0	1	100.0	8	18.6
All	8		15		8		1		45	

Missing data excluded – Case 5 =2,

Case 1 also saw 15 women aged over 20.

Table 84 shows the number of TAC attendees who had previously seen any other health professional for sexual health advice. Less than half of TAC attendees had not previously sought sexual health advice anywhere else. Fifty-eight percent (n=45) had previously seen someone else, including 16 (20.8%) who had already used normal GP services. For the remaining 32 (41.6%), TAC was their first use of any service.

Table 84: Previous Consultations

	Case 1		Case 2		Case 3		Case 4		Case 5	
Service used	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
GP	5	62.5	1	6.7	2	25.0	0	0.0	30*	75.0
FPC	0	0.0	3	20.0	0	0.0	0	0.0	1	2.5
A&E	0	0.0	1	6.7	0	0.0	0	0.0	0	0.0
School nurse	0	0.0	1	6.7	0	0.0	1	100.0	0	0.0
None	3	37.5	9	60.0	6	75.0	0	0.0	11	27.5

Missing data excluded – Case 5 = 5

*22 of those seeing their GP had previously attended a weekly, appointment based Family Planning Session based at the practice, 8 had used normal GP service.

Consultation outcomes in normal GP time and in TACS

There were some differences between those teenagers choosing to use TAC and those using normal general practice services. In particular the balance between those young women attending for regular contraception and those attending for "crisis" visits, a pregnancy test or emergency contraception (EC) was different. Overall, in 1999, less than a third of the teenage sexual health consultations in normal surgery time were for the "crisis" reasons of pregnancy tests or EC. There was a mean of 27.2% for case practices and a mean of 27.5% for control practices. In the TACs, over half (52.0%, n= 39) of the girls consulting came for emergency contraception or pregnancy tests (this includes one failed EC IUD fitting). This is higher than the average at GPs and is particularly striking given that the TAC service only ran once a week.

As in normal general practice, contraception was the most common outcome of consultations at TAC. However, a third (n=27) of attendees received condoms on their first visit, including 12 who received them in addition to their usual hormonal method. A quarter of those using the TAC (n=20) were under 16 years old, compared to an average of 10.7% of all those using the normal GP service at the ten study practices.

Results : Cost Of TAC Clinic Provision

Introduction

As described in chapter 2, each TAC clinic was provided with a pack of resources to meet the needs of those attending. These included comprehensive publicity and educational materials as well as supplies of contraceptives. Staff costs were also considerable. The only way in routine general practice to balance this expenditure is through claiming the annual contraceptive fee via FP1001 returns. Clearly the financial viability of such clinics depends on numbers attending, and in particular on numbers of new registrations for contraceptive services. The FP1001 system is fairly unhelpful as far as teenage drop-in services are concerned for the following reasons:

- The fee can only be claimed once a year and it covers any provision of contraceptive services including "advice". It is therefore not work-load related in any way It is relatively easy for a well organised practice to claim this fee for almost all its eligible

patients and there is little incentive to provide a more targeted and specialist services for particular groups such as teenagers.

- Teenagers are often very mobile and may need access to contraceptive services at several locations. Whilst anyone can access contraceptive services at any GP, the annual fee is paid only once and to one practice. This means that a drop-in service providing a comprehensive service to teenagers may not be able to claim a fee despite providing the majority of young person's contraceptive requirements. Moreover the claims procedure requires the submission of information (date of birth, name and address) that young people attending a drop-in may not wish to provide.
- The system does not allow claims to be made for male patients. A service that proved effective in attracting this group of clients would receive no extra funding.

Of course the annual fee system was not designed with anything other than routine GP services in mind. The indications from the pilot project however had been that it might be adaptable enough to cover a reasonable percentage of the running costs of the drop-ins (although we knew that set up costs would not be covered). As will be shown below, this did not prove to be the case within the study period. In fact the methods by which GPs are funded have undergone considerable change since the study ended, with the introduction of Personal Medical Services (PMS) contracts. These introduce a lot more flexibility into how a practice organises itself and it certainly would now be possible for a PMS practice to run a teenage drop-in service using savings generated elsewhere. Moreover a new GP contract is currently being negotiated and it may well be that provision of contraceptive services to teenagers will be a "quality target" which will attract additional funding.

Financial breakdown of TAC clinics

The figures below are based on the clinic being provided by a single trained nurse (at Grade F on the nurse pay scale). In practice in both the pilot project and most of the TAC clinics additional personnel helped out, either on a voluntary basis, or on some kind of secondment from elsewhere.

Many of the educational materials used are obtainable without charge and are not included in the figure given. Costs of contraceptives can be recouped by the practice, but the cost of on the spot pregnancy testing kits currently cannot. (These are included under "supplies")

Nurse time 1 hr a week	52 weeks @ £11.70	608.40
Publicity materials (posters, stickers, etc)		34.05
Supplies for TAC		283.76
Printing records		15
Leaflets for young people		27.04
Total		£968.25

For each patient advised about contraception, the practice is entitled to claim the annual contraceptive fee on form FP1001. This fee was £17.05 at the time of the project. The practices would therefore have to see 57 new drop-in clients each year to break even on providing this service. To pay nurse costs only would require 36 new clients. Clearly the numbers attending any of the TACs for this project were not high enough to make the drop-in self supporting and are expensive on a per person basis. Moreover all clinics in fact required additional staff to help the nurse who within the study were not remunerated.

However, family planning services in general are highly cost effective. It has been calculated that every pound spent on family planing services saves the NHS £11 due to avoiding unplanned pregnancies – any outcome of which is much more expensive than FP provision. Even greater cost benefits are incurred through the avoidance of social welfare payments[97].

Realistically from this study, it is not reasonable to suggest that GPs should provide dedicated drop-in services for teenagers without additional funding being available. Contraception is however as I have mentioned a very cost-effective measure for a government to provide in terms of costs saved. Additional funding for such clinics would have to be paid to practices via the Primary Care Trusts, although it may be that the new GP contract will provide sufficient incentives.

DISCUSSION

Despite evidence from one local general practice that the hour-long, weekly drop-in model can work, evidence from this controlled trial shows that this model may not be generalisible to all General Practices. This has been found in other studies where

observational studies show that interventions can be successful, while randomised studies show they are not.[98]

I think it likely that the relatively short running time (18 months) of the drop-in clinic study was a reason for the low numbers attending, at least in the two practices that saw significant numbers. It takes time for new services to become established and perhaps more importantly, trusted. However the main reason was that the intervention being tested was in fact a complex and (perhaps more importantly) a time consuming one, and for general practice outside of the normal "scope". It involved much more then the provision of a clinic once a week. What I think that we failed to do was to export the enthusiasm and perhaps the skills needed to engage with teenagers prior to the starting of the clinic. I discuss this important subject further in the final chapter.

Despite low attendance at the TACs, there appeared to be a different pattern of use to that at normal general practice services. TACs saw a higher proportion of under sixteen year old girls than normal GP services. In addition, a greater proportion of users attended in "crisis"; requiring EC or pregnancy tests even though the service only ran once a week. Rather than indicate poor access to regular contraception, higher EC use may actually show that provision is particularly appropriate for teenagers' needs, providing a service that gives easy access to emergency appointments and reflecting non-judgemental staff attitudes.

Those girls who have easy access to a FPC may choose to attend this for EC rather than their GP and this too may affect the figures shown. The Exeter FPC, which has open access six days a week, provided EC on more than 3000 occasions in 1998/99, half to teenagers. Of under 16s using the clinic, 57% of new users attended for the first time in "crisis", requiring EC, a pregnancy test or counselling about an unplanned pregnancy.[99] The TACs may be providing a service more closely allied to that offered by the FPC than the GP surgery.

The Exeter FPC is the only daily service in North and East Devon, with other FPCs open once or twice a week. Case 4 in this study is located in the same town as the FPC which may go some way to explaining the very low use of this TAC as an accessible alternative is available.

Despite a lack of alternative services, the focus group discussions suggested that teenagers living in smaller towns may be unwilling to use general practice based services because of their feelings of visibility and lack of privacy in these small communities.

Although the model of a weekly hour-long nurse led drop-in did not attract substantial numbers of teenagers, other service models – such as longer sessions, more frequent sessions, different staffing or different locations should be examined. However, in all cases local conditions (staffing, communication with other services, accessibility, and availability of other services etc.) need to be taken into consideration. In order to address the latest target to reduce teenage pregnancies[100] as well as rising rates of STIs such as chlamydia among sexually active young people, further innovative programmes aimed at teenagers are required. General Practice is the obvious place in which most of these programmes should be trialed, but they may include new locations for services such as schools, as well as new combinations of services such as co-operation between primary care and local pharmacies.

Chapter 5.

Critique of the project, summary and conclusions

In this chapter I shall try to reflect on this project. With the benefit of hindsight, I would have done some things differently and I shall offer some reflection on this. I shall also set the project in the context of new and significant initiatives that have been instituted since the project closed to try to reduce teenage conceptions in the UK. Finally I offer some conclusions that seem to me to be reasonable to draw from this work, and that I hope may be of some use to other researchers.

This project aimed to improve access to contraception for the majority of teenagers who obtain them from primary care services. The drop-in clinic format fulfilled many of the criteria suggested by my initial literature search (chapter 1) as being important to teenagers. The pilot project in my own practice had demonstrated that it could work and was popular. I was however very aware that the intervention in our case had comprised much more than the clinic itself. It had been built on a long process of reaching out to young people and much time spent talking with them (this was the reason for making the focus groups part of the intervention in case practices). Teenagers themselves had taken ownership of the drop-in service and had made it work. Our many meetings with parents, school teachers and youth workers had also produced a sense of community ownership of the service. Indeed many referrals to the clinic came from these sources. Our clinic staff enjoyed working with young people and were sympathetic to their needs. Our own research demonstrated so much need amongst our teenagers, and so many difficulties for them in accessing help that we were thoroughly committed to making the clinic work. Such enthusiasm is difficult to replicate and I was uncertain as to whether the drop-in model would be exportable to other practices. However there was good reason to try:

- Other sources of contraception for teenagers in Devon (particularly family planning services) were closing.

- The barriers to access that our research had demonstrated seemed to be common to primary care services generally (especially in rural areas).

- There was evidence that drop-in services were popular among teenagers and could work in other contexts.

In this chapter I shall consider whether our results suggest that the model was exportable. Also whether we could have done it better, and finally what lessons I have learnt. However things have moved on since the time of the project, and I shall now consider the project in the light of the new initiatives that are taking place nationally to reduce teenage pregnancy rates.

The National campaign to prevent teenage pregnancy

A year after the social exclusion unit report "Teenage Pregnancy" discussed in chapter one, a new Teenage Pregnancy Unit was set up at the Department of Health. This aims to take forward the 30 point action plan set out in chapter 11 of that report. The first action point was to set goals for teenage pregnancy - to halve the rate of conceptions among under 18s by 2010 and to set "a firmly established downward trend" in conception rates for under 16s by the same year. An interim target set out in the NHS plan [101] is of a 15% reduction by 2004. The rate in 1998, the year before the report was 46.5 conceptions per 1000 females aged 15-17 years. This will have to fall to 23.3 per 1000 by 2010 if the goal is to be reached. In support of these national directives all areas in England have appointed a local teenage pregnancy co-ordinator jointly nominated by health and local authorities, and a regional co-ordinator to support these local co-ordinators and provide links between local, regional and national agencies. In the South West of England a detailed report on patterns of teenage conceptions (1992-8) has been produced by the South West Public Health Observatory[102] in collaboration with local and regional teenage pregnancy co-ordinators. This report suggests that there will be much to do in the region if the governments' targets are to be reached. The data presented compare conception rates for under 18s for the periods 1992-4, 1995-7 and 1998. There has been an increase in the number of conceptions and the conception rate across the three periods for all the health authorities in the region and for the region as a whole. There has also been an increase in the rate of under 16 conceptions from 6.4 to 7.4 per 1000 women aged 13-15. Within this general increase there are wide variations both between and within Local Authority areas. For example in the period 1995-7 the under 18 conception rate was 18 per 1000 in North Dorset and 59 per 1000 in Swindon. Further analysis of these variations reveals a complex picture. In general high rates are found in areas of highest population density with lower rates in more rural areas. However some parts of

Cornwall have high rates and Penwith and the Isles of Scilly (neither with high population density) have had one of the biggest increases in rates over the study period. The issue of variation in teenage pregnancy rates is clearly crucial to understanding how to act in order to reduce rates generally. A recent report by the Teenage Pregnancy Unit[103] found that pockets of extremely high conception rates occur close to areas with no conceptions at all recorded for several years. A further study by Roger Ingham et al on behalf of the TPU[104] looked at rates in the years following the 1992 Health of the Nation report with its target of halving national rates (from 9.6 per 1000 women 13-15 years to 4.8 per 1000) by the year 2000. Clearly this strategy was not terribly effective (the rate in this age group for England was 8.3 per 1000). However consideration of national rates disguises big changes between Health Authorities over this period. At one extreme, reductions of around one quarter had been achieved, whilst at the other end of the spectrum there had been an increase of over one half. The study set out to explore factors responsible for such variations. They found that of the 105 Health Authorities in England, 47 showed an increase in rates, 22 a decrease and 36 no change. The range was from an increase of 55% to a decrease of 28%. Interestingly, South and West Devon (neighbouring the project area) was one of the areas showing a big increase of 21.1%. The study found that Health Authorities had shown a very variable response to the Health of the Nation report. Some had apparently done nothing at all and others had created new posts, established various working parties and conducted needs assessments. It was felt that the degree of enthusiasm and commitment was a crucial factor, but very difficult to measure or quantify. The major theme to emerge from the study was the extent to which specialist young people's services had or had not been developed in an area. This was the factor that distinguished best between those areas with increasing and those with decreasing rates. Other factors included new initiatives in school sex-education and the setting up of inter- agency groups to tackle the problem. The conclusion of this study was that those areas that addressed the issues more comprehensively achieved a reduction in rates.

Continuing the theme of "what works" in reducing teenage conception rates, a report by the NHS Health Development Agency[105], whilst emphasising that programmes to address the problem need to be multi-faceted (including such areas as reduction in poverty amongst young people) considers that effective interventions will involve increased availability of youth-based contraceptive services. This is reinforced by a recent "review of reviews"[106] which showed that reduced teenage pregnancy rates are associated with increased provision of such services.

It seems then that our emphasis on improving access to contraceptive services to teenagers is justified by recent studies. Is there any guidance about how this should be done against which our project could be judged? The Teenage Pregnancy Unit has produced "best practice guidelines" for the provision of effective services[107]. The recommendations in this report include:

- Involving young people. Services should be planned and evaluated in consultation with young people.
- Confidentiality. Services should have an explicit confidentiality policy.
- Location. Services should offer easy access and anonymity for young people.
- Services provided. A full range of contraceptive services should be available, including emergency contraception, pregnancy testing and appropriate referral for STIs and abortion.
- Publicity. This should "have resonance" with young people and should be available in places such as schools and colleges where teenagers go.
- Staff attitudes. Staff should be friendly and non-judgemental. They should try to create a comfortable and non-clinical atmosphere.

Teenage drop-in clinics in General Practice can fulfil many of these criteria. In fact most of them are things that we explicitly addressed in the pilot project and tried to carry over into the intervention clinics.

Critique of the project

Whilst visits by young people for contraception did increase in intervention practices compared to controls (by 2.03% as against a 2.22% fall in control practices), the project did not achieve our target of a 10% increase in visits. In retrospect this was probably an over-ambitious target in a group that are acknowledged to be very difficult to reach and with only one clinic a week. Moreover it could be argued that the best outcome variable to use would not be provision of contraception but evidence of its effective use (in a study in Devon on pregnant teenagers, 80% claimed to be using contraception at conception[108]!) However this would be a very difficult thing to measure, other than by teenage conception rates, which are very difficult to use in a relatively small project. Other criticisms are that the drop-in clinics ran only for one hour per week and the project itself for only 18 months. The length of time that the clinics could run was limited by availability of staff and by cost. The length of the project itself was originally

planned to be 12 months. This was extended to 18 months, but in retrospect 24 or even 36 months would have been better. It is however difficult to maintain a research project for that length of time, particularly in busy general practices with many other demands on staff time and our funding did not allow a longer intervention period.

Considering these limitations, I am still enthusiastic about the use of teenage drop-in clinics in General Practice. Many (25%) of those attending were under 16 and 42% had not previously used any other service. Moreover most of those attending were given contraception and over half attended for a "crisis" reason such as emergency contraception or pregnancy testing. Extrapolating from these results, a regular longer (say 2 hour) clinic held more often (perhaps twice weekly) and running for long enough to build up trust and to become widely known might make a very significant contribution to reducing teenage pregnancy. Considering the large numbers of General Practices, their accessibility and the advantages of basing services in a general health setting (discussed in chapter 1) it is my belief that such clinics should become the norm for contraception provision for teenagers in General Practice. Certainly they could form a very useful part of what the Teenage Pregnancy Unit (in the references already discussed) calls a "joined up" approach to tackling the problem of teenage pregnancy. Like so much else in the provision of health services, it comes down to cost. The clinics cost (at the time of the project) around £1000 per year to run, and would cost more if run for longer and more often as I have suggested. However if sufficient numbers attend some of the cost can be recouped via contraceptive fees (the pilot project, and the most successful of the TAC clinics just about broke even as regards running expenses). If viewed from the perspective of the whole NHS, such clinics might be extremely cost effective. The NHSE National Schedule of Reference Costs (1999), together with the Faculty of Family Planning and Reproductive Health calculate that an average investment of £80 per year to provide contraception to a teenager under 18, will result in a direct saving on maternity costs or abortion to the health budget of £750 for each pregnancy prevented. Unfortunately, such savings would not get back to the GP surgeries. These are, in general run as small businesses with self-employed doctors. This makes each practice very much unique, a fact that becomes very obvious when doing research such as the project that I have described. It simply is not possible to replicate exactly something that has worked in one practice in another. I spent many hours visiting the project practices and following up with letters and telephone calls. The truth is that some responded enthusiastically and took over "ownership" of the drop-ins, and others did not (indeed, one intervention practice I must say did the minimum possible within the agreement to

participate in the project). Unsurprisingly, it was in those practices (and in the case 5 practice in particular) where staff replicated the commitment and enthusiasm of the South Molton pilot project that the drop-in was successful. Indeed the drop-ins are still running very well in the pilot practice and the case 5 practice.

In this sense this project, with all its limitations was, I submit a good one. It tested an intervention that had been shown to work under perhaps "ideal" conditions, in the real world of day to day General Practice. I have found an article by an Epidemiologist, Brian Haynes[109] very useful in considering this. He makes the point that many (probably most) trials are done under very carefully controlled conditions, unlike those found in most of the health service. Such trials tell us if an intervention *can* work. In my case the pilot project had shown that a drop-in clinic *could* work. The real question however is whether an intervention *does* work in the real world (in my case the real world of variable General Practice). My results for this are less convincing. (although, as I have argued above, the TAC clinics did have some effect despite their short duration). Haynes' final test is "is it worth it", that is in financial terms. My answer is; probably not to an individual practice, but very possibly to the health service overall.

This study has at least tried to find out the answer to the second question (does it work?) and made a stab at answering the third (is it worth it?)!

Summary and Conclusions

This project set out to test what was in fact a complex intervention. I knew that simply starting up drop-in clinics in some practices would not reproduce what we had done in South Molton and would be unlikely to work. We tried therefore to export the whole model of initial contacts with local teenagers (and their parents and teachers) followed by Focus Group Discussions to determine the local configuration of the clinics. I think that this was correct in principle, but in reality some practices seem to have "gone through the motions" without much commitment. We also carried out what turned out to be a very large and time consuming, but fascinating descriptive project amongst young people in North and East Devon.

The clinics had very variable success. One (case 4) managed to attract just one teenager in the entire 18 months of the project (only slightly mitigated by the fact that this individual attended on 4 occasions!). Another, in a much smaller and poorer resourced practice saw 45 teenagers for 79 visits. 10 of these young people had never attended any service before and 10 had had unprotected intercourse and required Emergency Contraception on the first visit.

The descriptive project generated enormous amounts of mostly qualitative information. I feel privileged to have been able to become immersed for countless hours in its recording and interpretation. It is difficult to summarise what I feel have been significant insights into the lives of the many young people that participated in the various parts of the study. Certainly my initial concerns about the presence of significant barriers for teenagers in accessing contraception have been strongly confirmed. Some exist because of unhelpful, intolerant or plain ignorant attitudes amongst health professionals when dealing with sexually active young people. Fortunately this seems to be relatively uncommon and there were many examples of young people expressing great trust in the doctors and nurses that they knew. Confidentiality and (particularly in rural areas) anonymity were very major problems for many teenagers. There were pros and cons of basing services in General Practice in this regard. Simple measures and just greater awareness of the problem amongst staff could make a big difference (there were many references to information being visible to parents and others on computer screens during consultations with young people for example). Practices could also do more to publicise a strictly confidential policy to young people. It was overwhelmingly their parents that our teenagers did not want to find out about their sexual activity. This may be the key to reducing teenage pregnancy in the long term. A more open attitude amongst parents and society about teenage sexuality (indeed, to sexuality in general!); more discussion, more information at all levels about relationships, sex, sexually transmitted diseases and contraception seems to me to be a prerequisite for tackling teenage pregnancy. Embarrassment was mentioned more than any other word in the context of sexuality! Perhaps that is why so many young people are astonishingly ignorant about their bodies, about the health service in general and contraceptive services in particular. For many (probably most) teenagers, first sex is not planned or prepared for, may not be enjoyable, may be regretted and contraception is not arranged first. Many become sexually active very young (a fifth of 13-14 year old girls and 16.5% of boys according to our school survey. The female bias was confirmed in the teenagers' evaluation of GP services study, in which 39.4% of girls 16 and younger but only 13.3% of boys claimed to be sexually active). Some (about a third of sexually active 15-16 year olds and a quarter of 13-14 year olds) claim to have had four or more sexual partners by the age of 16. Even when the decision is made to use contraception, many young people are not sure where to get it or have all kinds of internal (embarrassment etc) and external (transport, time, money) problems in obtaining it. A majority of sexually active teenagers "sometimes" have sex without using contraception. Many are very ill informed about Emergency Contraception and Sexually Transmitted Diseases. Becoming pregnant is in general frowned upon and

considered a bad idea when young. Abortion is feared (perhaps more than is justified by the facts) and unpopular. Sex education in school is not considered of good quality or felt to be very useful. Boys particularly do not feel that it is relevant to them (mostly because they consider that they "know it already" although from what source is not clear!). Friends and magazines are the prime source of information for both sexes. There is general agreement that sex education is "too little, too late" and that it concentrates too much on physical facts rather than on relationships. Parents (especially fathers) are not generally seen as a source of information or help. Sex can be completely detached from emotional relationships, especially when alcohol is involved (which is common) and this is not always considered to be a bad thing (especially, but not only among boys). STDs are perceived as a serious issue requiring medical treatment. Few of our teenagers had heard of Genito-Urinary Medicine clinics and most considered that the GP was the place to go for help. Visiting the GP for any matter related to sexual health is a stressful experience for many young people. The need to go through a receptionist is a particular barrier (especially for Emergency Contraception), but embarrassment exists at every stage. Some under 16s are not sure if they are "allowed" to go on their own and are concerned that their parents will be told (in the GP survey a few doctors thought that the parents should be!). In rural areas problems of transport are a major difficulty for teenagers. Most young people in our studies were aware that the GP could provide contraceptive services. Doctors were not however seen as an appropriate source of advice about sex or relationships. Family Planning Clinics were popular among some teenagers, but were too remote for many. Some were confused about what such clinics did (the name is confusing to many young people). Overall FPCs were not a major source of contraceptive provision, with the notable exception of one clinic in Exeter which sees very large numbers. (This clinic is run by a very dedicated female doctor and has made big efforts to reach young people). School nurses were liked by many of our young people and are probably an under utilised resource in terms of promoting teenage sexual health. For most teenagers their friends and peer group are by far the most important source of advice and information about sexual matters. Girl's relationships seem in general to be helpful in this regard, but for boys there is less trust and more competition. Many boys seemed very unsupported in working out issues of sexuality. They were also notably less likely to participate fully in the FGDs, and very few attended any of the TAC clinics. Involving boys in decisions regarding contraception may be a further key area to address in tackling the problem of teenage pregnancy.

What would I do differently?

At the end of a project that I have lived with and worked on for nearly 8 years it is a good time to take stock and reflect on lessons learnt. There are many. The unexpected difficulty of producing a usable questionnaire and the amazing number of revisions necessary to get it right. The frustration of trying to inspire colleagues with an idea that has gripped you, but which may be for them just another extra job. The excitement of meeting and working with all sorts of wonderful people who are concerned about young people. Fascination, surprise and sometimes hilarity in going through the transcripts of interviews. Insights into other peoples work as you read papers and understand why certain things were done or not done. The anxiety that someone else will do exactly the same study as you (and do it better!). Overall though it has been a wonderful experience and I believe it to be a useful study on a very important topic. If I was doing it again I would seek funding and support for a much longer study (probably 3 years) because young peoples trust is slow to build up. I would be more focussed and not try to do so many things at once. I would explore other venues for drop-in clinics such as schools, and I would spend even more time in involving not only teenagers but parents, teachers and community groups in the planning (and even the running) of the clinics.

My original patient will be in her mid twenties now, and her child almost a teenager himself. There are some grounds for hoping that his generation will be less likely than that of his mother to become teenage parents. Teenage conception rates for the last 2 years have fallen. Recent figures from the Office of National Statistics show that the under 18 conception rate fell by 2.4% from its 1999 level and is now 6.3% below the 1998 level. The under 16 rate has also fallen since 1998 by about 6.2%. The rates are still high by European standards, and there have been fluctuations before, so it may be too early to predict how likely we are to reach the government target of halving the rates by 2010. However there is certainly more concerted action, more "joined up thinking" and more commitment to tackling the problem than there was at the time that this project started. Whether a more open attitude towards sexuality will emerge in Britain and some of the barriers to teenagers getting access to contraception will be removed remains to be seen. There is, in my view, too little emphasis on the role of Primary Care as a provider of contraceptive services for teenagers in the new Teenage Pregnancy Strategy. They should remember that 80% of contraceptive provision for teenagers takes place in General Practice.

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Appendices

List of Appendices

Appendix 1. FGD questionnaire and details of participants

1. **AGE:** _____ *1-2*

2. **SEX:** ❒$_1$ MALE
❒$_2$ FEMALE *3*

3. **ARE YOU:** ❒$_1$ AT SCHOOL YEAR _____ *5-6*
❒$_2$ AT COLLEGE
❒$_3$ WORKING
❒$_4$ LOOKING FOR WORK
❒$_5$ OTHER (Please say what) _____ *4*

4. **HAVE YOU EVER VISITED OR USED THE FOLLOWING FOR SEXUAL HEALTH ADVICE OR CONTRACEPTION? (Tick all you have used)**

❒ FAMILY PLANNING CLINIC
❒ YOUR OWN DOCTOR/GP
❒ ANOTHER DOCTOR GP
❒ SCHOOL NURSE
❒ YOUTH WORKER
❒ OTHER (Please say what/who): _____ *7-12*

5. **HAVE YOU EVER HAD SEX?** ❒$_1$ YES
❒$_2$ NO → Thank you for your help. You do not need to answer any more questions. *13*

6. **HOW OLD WERE YOU THE FIRST TIME YOU HAD SEX?** ____YEARS *14-15*

7. **HOW MANY PEOPLE HAVE YOU HAD SEX WITH?** _____ *16*

8. **HAVE YOU EVER HAD SEX WITHOUT USING ANY CONTRACEPTION?**

❒$_1$ NO
❒$_2$ YES *17*

9. **DO YOU USUALLY USE CONTRACEPTION WHEN YOU HAVE SEX?**

❒$_1$ NO *18*
❒$_2$ YES → WHAT DO YOU USUALLY USE? _____ *19*
(Pill, condom, injection etc.)
↘
WHERE DO YOU GET THIS? _____ *20*
(Family Planning Clinic, GP, chemist etc.)

Focus group participants

Greyville

All doing GCSE this year - most planning on further training or A-levels one wants to join the Marines. Friendship group. Recruited through school counsellor/youth worker - interview in school time but at seafront young people's cafe.

BOYS	1	2	3	4
Age	15	15	15	16
Occupation	Year 11	Year 11	Year 11	Year 11
Used FPC	×	×	×	×
Used Own GP	✓	✓	×	×
Used other GP	×	×	×	×
Used school nurse	×	×	×	×
Used Youth Worker	×	×	×	×
Used Other	×	×	×	×
Had sex?	Yes	Yes	No	Yes
Age at first sex	15	15	-	15
How many people	1	1	-	1
Unprotection sex?	No	No	-	Yes
Regular contraceptive	Condom	Condom	-	-
Source	Pub	Machine	-	Family Planning

Greyville girls - all in lower IVth at Greyville college. Friendship group. Same arrangements as boys.

GIRLS	1	2	3	4	5	6	7	8
Age	17	16	17	17	17	16	17	16
Occupation	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12
Used FPC	×	✓	✓	✓	×	×	×	×
Used Own GP	✓	×	×	×	×	✓	✓	×
Used other GP	×	✓	×	✓	×	✓	✓	✓
Used school nurse	✓	×	×	✓	✓	×	×	×
Used Youth Worker	×	✓	×	×	×	×	×	×
Used Other	×	×	×	×	practice nurse	nurse	×	×
Had sex?	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Age at first sex	14	14	15	15	14	15	15	14
How many people	4	5	2	2	5	3	2	2
Unprotected sex?	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Regular contraceptive	condom	Depo	Pill + condom	Pill condom	condom/ pill	inject-ion	Pill	condom
Source	FPC	FPC	FPC	FPC/ GP	-	GP	GP	chemist

Greyville younger girls 11/10/99 as above

GIRLS	1	2	3	4	5	6	7	8	9
Age	15	15	14	14	15	14	15	14	13
Occupation	Y. 11	Y.10	Y. 9	Y. 10 +	Y. 10	Y. 10	Y. 10	Y. 10	Y. 9
Used FPC	×	✓	✓	×	✓	✓	✓	×	×
Used Own GP	✓	×	✓	×	×	✓	×	×	×
Used other GP	×	×	×	×	×	×	×	×	×
Used school nurse	✓	×	✓	×	✓	×	×	×	×
Used Youth Worker	✓	×	×	×	×	×	×	✓	✓
Used Other	×	×	mu m	×	×	×	×	×	×
Had sex?	yes	no	no	yes	yes	yes	yes	yes	no
Age at first sex	15	-	-	14	14	14	14	13	-
How many people	3	-	-	1	1	1	1	1	-
Unprotected sex?	yes	-	-	yes	yes	yes	yes	no	-
Regular contraceptive	none	-	-	condom	condom	yes	condo m rhyth m	condom	-
Source	-	-	-	-	fpc	-	-	friends	-

Older Greyville boys 11/3/99

BOYS	1	2	3	4	5	6	7
Age	17	17	16	17	17	16	17
Occupation	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12	Y. 12
Used FPC	×	×	×	×	×	×	×
Used Own GP	×	×	×	×	×	×	×
Used other GP	×	×	×	×	×	×	×
Used school nurse	×	×	×	×	×	×	×
Used Youth Worker	✓	✓	×	×	✓	✓	✓
Used Other	×	friends + family	×	×	×	×	×
Had sex?	yes	yes	yes	no	no	yes	no
Age at first sex	15	14	14	-	-	15	-
How many people	4	5 or 6	1	-	-	2	-
Unprotected sex?	no	no	no	-	-	no	-
Regular contraceptive	condom	condom	pill	-	-	condom	-
Source	youth club	youth club - pub	chemist	-	-	youth club / chemist	-

Blueham .5 girls in one group, 4 boys in other. Recruited through youth workers - most on apprentice/training schemes or work experience. Took place at Youth Centre but not totally private and noisy due to road. Day time session

GIRLS	1	2	3	4	5
Age	18	16	16	16	17
Occupation	Looking for work	Looking for work	Looking for work	Looking for work	Looking for work
Used FPC	×	×	✓	×	×
Used Own GP	×	✓	×	×	×
Used other GP	×	✓	×	×	×
Used school nurse	×	×	×	×	×
Used Youth Worker	×	×	×	×	×
Used Other	×	×	×	×	×
Had sex?	No	Yes	No	No	No
Age at first sex	-	15	-	-	-
How many people	-	3	-	-	-
Unprotected sex?	-	Yes	-	-	-
Regular contraceptive	-	pill condom	-	-	-
Source	-	-	-	-	-

BOYS	1	2	3	4
Age	16	17	15	16
Occupation	Looking for work	Looking for work	Y. 11	looking for work
Used FPC	×	×	×	×
Used Own GP	×	×	×	×
Used other GP	×	×	×	×
Used school nurse	×	×	×	✓
Used Youth Worker	×	✓	×	×
Used Other	×	×	family/friend/ girlfriend	×
Had sex?	No	Yes	Yes	Yes
Age at first sex	-	15	14	15
How many people	-	16-25	2	3
Unprotected sex?	-	Yes	Yes	No
Regular contraceptive	condom	Yes	Condom/pill	condom
Source	chemist	-	Drop-in clinic	chemist

Blueham 2 Boys and girls all 13 to 16 - at school and college. Recruited through Youth service - some knew each other, others didn't. Evening session at Youth Centre.

BOYS	1	2	3	4	5	6	7
Age	16	15	13	13	14	15	14
Occupation	College	School	Y. 9	School	Y. 10	Y. 11	Y. 10
Used FPC	×	×	×	×	×	×	×
Used Own GP	×	×	×	×	×	×	×
Used other GP	×	×	×	×	×	×	×
Used school nurse	×	×	×	×	×	×	×
Used Youth Worker	×	×	×	✓	×	×	×
Used Other	×	×	×	×	×	×	×
Had sex?	No	Yes	No	No	No	Yes	No
Age at first sex	-	12	-	-	-	15	-
How many people	-	2	-	-	-	1	-
Unprotected sex?	-	Yes	-	-	-	No	-
Regular contraceptive	condom	None	-	-	-	condom	-
Source		-	-	-	-	chemist	-

GIRLS

	1	2	3	4	5
Age	13	14	13	14	14
Occupation	Y. 9	Y. 10	Y. 9	Y. 10	Y. 10
Used FPC	×	×	×	×	×
Used Own GP	×	×	×	×	×
Used other GP	×	×	×	×	×
Used school nurse	×	×	×	×	×
Used Youth Worker	×	×	×	×	×
Used Other	×	×	×	×	×
Had sex?	No	Yes	No	No	Yes
Age at first sex	-	12	-	-	13
How many people	-	4	-	-	1
Unprotected sex?	-	Yes	-	-	Yes
Regular contraceptive	-	condom	-	-	-
Source	-	shops	-	-	-

Brownton. Recruited through youth outreach from group that "hang out" at bus-stop . Taken to library for FGD. Evening session. Friendship group.

GIRLS	1	2	3	4	5	6
Age	13	14	13	14	13	15
Occupation	Y. 9	Y. 9	Y. 9	Y. 10	Y. 9	Y. 11
Used FPC	×	×	×	×	×	×
Used Own GP	✓	✓	×	×	✓	×
Used other GP	×	×	×	×	✓	×
Used school nurse	✓	✓	×	×	✓	×
Used Youth Worker	✓	✓	×	✓	×	✓
Used Other	×	×	×	×	×	×
Had sex?	Yes	Yes	Yes	No	Yes	Yes
Age at first sex	13	13	12	-	13	14
How many people	1	5	1	-	1	2
Unprotected sex?	Yes	Yes	No	-	Yes	Yes
Regular contraceptive	Yes	sometimes - pill, condom	condoms	-	pill condom	Yes
Source	GP	GP	Wherever	-	clinic GP	-

Greenham

12/12/98 - recruited through youth worker. Saturday session done at Youth Club. Friendship groups

GIRLS	1	2	3	4
Age	13	13	13	13
Occupation	Y. 9	Y. 9	Y. 9	Y. 9
Used FPC	×	✓	×	✓
Used Own GP	×	×	×	×
Used other GP	×	×	×	×
Used school nurse	×	✓	×	✓
Used Youth Worker	×	✓	×	✓
Used Other	×	sister	×	parents/friends
Had sex?	No	No	No	Yes
Age at first sex	-	-	-	13
How many people	-	-	-	1
Unprotected sex?	-	-	-	No
Regular contraceptive	-	-	-	Condom
Source	-	-	-	GP

BOYS	1	2
Age	13	14
Occupation	Y. 9	Y. 9
Used FPC	×	×
Used Own GP	×	×
Used other GP	×	×
Used school nurse	×	×
Used Youth Worker	×	×
Used Other	×	Teacher
Had sex?	No	No
Age at first sex	-	-
How many people	-	-
Unprotected sex?	-	-
Regular contraceptive	-	-
Source	-	-

GREENHAM BOYS AGED 16-18 Recruited from sixth form by tutor. Friendship group. Conducted at lunchtime on school premises.

BOYS	1	2	3	4	5	6
Age	18	18	16	17	18	16
Occupation	Vith form	Vith form	Vith form	Vith form	Vith form	Vith form
Used FPC	×	×	×	×	×	×
Used Own GP	×	×	×	×	×	×
Used other GP	×	×	×	×	×	×
Used school nurse	✓	✓	×	×	×	×
Used Youth Worker	×	×	×	×	×	×
Used Other	Brother, pub	Mates	×	×	×	×
Had sex?	Yes	Yes	Yes	No	Yes	Yes
Age at first sex	15	16	15	-	17	15
How many people	4	1	7	-	5	1
Unprotected sex?	Yes	No	Yes	-	No	No
Regular contraceptive	Condom	Condom	Condom, pill	-	Condom	Condom
Source	Brother, pub	School nurse, chemist, pub	Pub	-	Mates	Pub

GREENHAM GIRLS AGED 16-17 Recruited from sixth form by tutor. Friendship group. Conducted at lunchtime on school premises.

GIRLS	1	2	3	4	5	6	7
Age	17	17	16	17	16	16	17
Occupation	YR 12	YR 12	YR 12	YR 12	YR 12	YR 12	YR 12
Used FPC	✓	×	×	×	✓	✓	✓
Used Own GP	✓	×	✓	×	✓	✓	×
Used other GP	✓	×	×	×	×	✓	✓
Used school nurse	×	×	×	×	×	×	×
Used Youth Worker	×	×	×	×	×	×	×
Used Other	×	×	×	×	×	×	×
Had sex?	Yes	No	Yes	Yes	Yes	Yes	Yes
Age at first sex	14	-	14	16	15	15	14
How many people	2	-	2	2	1	2	3
Unprotected sex?	No	-	No	No	No	No	No
Regular contraceptive	Pill	-	Pill	Condoms	Pill + condoms (sometimes)	Pill + condom	Pill + condom
Source	GP	-	GP	Chemist	GP /chemist	GP / FPC	FPC

Brownton and surrounds. took place at lunchtime at VIth form college. Recruited by college nurse. Some knew each other, others new to group.

GIRLS	1	2	3	4	5	6	7
Age	18	17	17	17	19	18	17
Occupation	College	College	College	College	College	College	College
Used FPC	×	×	×	×	×	×	×
Used Own GP	✓	×	×	×	✓	✓	×
Used other GP	✓	×	✓	×	×	×	×
Used school nurse	×	✓	×	×	✓	✓	×
Used Youth Worker	×	×	×	×	×	×	✓
Used Other	×	×	×	×	×	college doctor	×
Had sex?	Yes	No	No	No	Yes	Yes	No
Age at first sex	17	-	-	-	15	15	-
How many people	1	-	-	-	4	3	-
Unprotected sex?	No	-	-	-	Yes	No	-
Regular contraceptive	Pill + condom	-	-	-	Pill/ condom	Pill + condom	-
Source	GP - chemist	-	-	-	Doctor/ college nurse	GP	-

BOYS	1	2	3	4	5	6	7
Age	18	18	19	16	16	17	19
Occupation	College	College	College	College	College	College	College
Used FPC	×	×	×	×	×	×	✓
Used Own GP	×	×	×	✓	×	×	✓
Used other GP	×	×	×	×	×	×	×
Used school nurse	×	×	×	×	×	×	✓
Used Youth Worker	×	×	×	×	×	✓	×
Used Other	×	×	×	×	×	×	×
Had sex?	No	Yes	Yes	Yes	Yes	Yes	Yes
Age at first sex	6	14	-	15	14	15	14
How many people	6	3	-	1	4	2	18
Unprotected sex?	No	No	No	No	Yes	No	Yes
Regular contraceptive	condom	condom	Pill	condom	Pill	condom/ pill	Condom /pill
Source	GP	nurse	Doc.	-	-	Chemist	Family Planning

Redton Recruited by college nurse at Redton college

GIRLS	1	2	3	4	5
Age	17	16	17	17	16
Occupation	College	College	College	College	College
Used FPC	✓	✓	×	×	×
Used Own GP	×	×	×	×	×
Used other GP	×	✓	×	×	×
Used school nurse	×	✓	×	×	×
Used Youth Worker	×	×	×	×	×
Used Other	college nurse	×	college nurse	no	no
Had sex?	Yes	Yes	Yes	No	No
Age at first sex	13	14	6	-	-
How many people	6	1	4	-	-
Unprotected sex?	yes	Yes	Yes	-	-
Regular contraceptive	None	pill + condom	None	-	-
Source	-	FPC + college nurse	-	-	-

Redton Boys Recruited through college nurse. All on an NVQ building skills course. Friendship group

BOYS	1	2	3	4	5	6
Age	16	17	17	17	16	19
Occupation	College	college/ working	college/ working	college/ working	college	college
Used FPC	×	×	×	×	✓	✓
Used Own GP	×	×	×	✓	✓	×
Used other GP	×	×	×	✓	×	×
Used school nurse	×	×	×	×	×	×
Used Youth Worker	×	×	×	×	×	×
Used Other	×	×	×	×	×	×
Had sex?	yes	yes	yes	yes	yes	yes
Age at first sex	15	17	16	16	13	16
How many people	4	1	1	1	3	4
Unprotected sex?	yes	no	no	no	no	yes
Regular contraceptive	condom	condom	pill	condom	condom	pill/ condom
Source	shop	College nurse	GP	mates	-	fpc, gp

Appendix 2

FGD QUESTION ROUTE
DROP-IN CLINICS FOR TEENAGERS IN PRIMARY CARE

PREAMBLE

First of all, thank you all for coming here today. I'd like to start by giving you a little background information about this project. The S&W Regional NHS has funded this research to look at teenagers' sexual health needs in North and East Devon. As part of this study, I shall be talking to young men and women in groups like this about what services you know about in the local area, what you think of them and what you would like to see.

The discussion will last about an hour. It will be tape recorded so that I can remember accurately what has been said, and you may also see me making some notes. The tape will be transcribed at the University and then erased - so don't worry about it. Whatever you say will be treated as completely confidential, and no-one will be able to trace your comments to you. We will use first names in the sessions but these will be changed when the tape is transcribed. What you say will be used together with other findings from the study. I would also ask you to respect each other during this session, and to not use anything said here outside this room. - Can everyone agree to that?

During the discussion, please remember that I am interested in all your opinions - there are no right or wrong answers, and I want to hear from you whether you agree or disagree with something that has been said. This is not about knowledge so much as attitudes and feelings - if you don't know about something please say so. It is the responsibility of the services to provide good information. The whole point of the exercise is to find out what your views are, so please say what you really think. If you don't want to talk about yourself you can always answer in terms of "my friend did this..." if you like.

Please try and speak one at a time - its difficult to decipher the tape recording if people talk over each other. I want you to be comfortable while you talk so use the language you are used to using with your friends. Finally, please let everyone have a turn at saying something - everyone's views are important.

INTRODUCTIONS AND ICE-BREAKING - 10 minutes

Ask each participant individually -

1. Their FIRST name
2. What courses or jobs they are doing

Ask the group -

1. What sex education did you receive at school?
   Was this useful?

PROMPT: *age,*
who taught it
what it did and didn't cover (abortion, relationships, homosexuality)
separate girls and boys groups
do you feel that this was useful?

DISCUSSION OF DILEMMAS - 20 minutes

(To establish what services are known about and which would be used)

2. Where would you advise a friend to go, or who would you tell them to talk to if:

- They wanted to find out more about contraception
- They wanted to get condoms (*PROMPT - free of charge)*
- They thought that they may have caught something from having sex
- They had used a condom but it had broken in use. (*PROMPT EC, time limits, locations)*
- They (or their partner) had an unplanned pregnancy
- They were thinking of having sex for the first time, and wanted to talk to someone about it.

2. So, for the situations we have just talked about, how useful do you think the following people would be to talk to?

- teacher/school nurse
- GP
- FPC staff
- friends
- brother/sisters/relatives
- parents (*prompt mum or dad)*

PROMPT WHY?

DISCUSSION OF SERVICES 25 minutes

3. What places are there locally that you know of which offer advice and information about sex and contraception?

List these

4. Take the places that have been mentioned one at a time

- How many people knew they could go/ had heard of _____? *(Show of hands - COUNT!)*
- How do people know out about _____?
- Is it easy to get information about _____?
- Do you know where _____ is? Do you know when it is open?
- Do you know what kind of services are offered? *(PROMPT-does this seem adequate)*
- What kind of reputation does it have? Do young people like it? Do they tell their friends about it?
- Do people use _____ ? Why/why not?

5. There are some other services that could be used which haven't been mentioned, which can be used for sexual health advice and contraception: *(take these one at a time)*

- How many people have heard of _____? *(Show of hands - COUNT!)*
- How do people find out about _____?
- Is it easy to get information about _____?
- Do you know where _____ is? Do you know when it is open?
- Do you know what kind of services are offered? *(PROMPT-does this seem adequate)*
- What kind of place do you think this might be? Why do you say that
- Do people use _____ ? Why/why not?

USE ANSWERS TO QUESTIONS 4 AND 5 TO DRAW OUT COMPARISONS OPINIONS OF FPC VS. GP - also why used by girls and not boys?

If appropriate to previous section answers ask:

6. Is there anything that the GP could do to make you more likely to talk to them about sexual health? *(PROMPT: opening hours, appointments, staff attitude, seeing a nurse, free condoms, venue etc.))*
Would you be more comfortable talking about these issues to a man?

If there is time and boys have little to say about services:

7. Who do you think is responsible for contraception if:
You have a one night stand
You have a casual relationship
You have a long term relationship

8. What do you think of condoms? *(PROMPT:* buying/obtaining, carrying, deciding to use, putting on, comfort)

Thank you very much for talking to me about these issues, before you go - please will you fill in this short questionnaire to give some background information about yourselves - complete it and fold it and put it in this envelope - all your answers are anonymous and confidential.

GENERAL PRACTITIONERS AND SEXUAL HEALTH FOR THE UNDER 16S

ID *1-3* ☐

1.) **Age:** ☐ years *4-5*

2.) **Sex:** ☐1 Male ☐2 Female *6*

3.) **Do you have any further training in Family Planning?** ☐1 Yes ☐2 No *7*
(for example the FPA certificate, DFFP, MRCOG etc.?)

4.) **Please show how much you agree or disagree with the following statements:**

Where I see girls who are under 16 and having a sexual relationship, I would prefer that their parents knew they had sought contraception from me.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *8*

Where I see girls who are under 16 and having a sexual relationship, I would prefer that their parents knew they had sought my advice.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *9*

If I supply contraception to an under 16 year old girl, I am aiding a criminal act.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *10*

I owe the same duty of confidentiality to under 16s as to my other patients who are over 16.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *11*

I would try to persuade an under 16 year old to wait until they were older before they have sex.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *12*

I think that most under 16 year old girls are too immature to be having sex.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *13*

Allowing the under 16s access to contraception only encourages underage sex.
☐1 Strongly Agree ☐2 Agree ☐3 Neither agree nor disagree ☐4 Disagree ☐5 Strongly disagree *14*

5.) **How many times a month do you see under 16 year old girls for sexual health/ contraception?**

18 ☐ Times a month *15-16*

6.) **How many times a month do you see under 16 year old boys for sexual health /contraception?**

☐ Times a month *17-*

7.) **Compared to other partners in your practice, would you say that this is:**
☐1 Less frequently than others *19*
☐2 About the same
☐3 More frequently than others
☐4 Don't know

8.) **In terms of sexual health, what do under 16 year old girls most often approach you about? (Tick ONE only)**

☐1 Emergency contraception *20*
☐2 Contraceptive pills
☐3 Advice about contraception
☐4 Condoms
☐5 Pregnancy tests
☐6 Other (please state)_____

PTO

9.) Do you follow written guidelines about treating under 16s for sexual health advice and contraception?

☐1 No
☐2 Yes → **What guidelines?** _____ *22*
21

10.) In general, how do you feel about supplying contraception to under 16s?

☐1 Very Uncomfortable
☐2 Uncomfortable
☐3 OK
☐4 Comfortable
☐5 Very Comfortable *23*

11.) In general, how do you feel about giving sexual health advice to under 16s?

☐1 Very Uncomfortable
☐2 Uncomfortable
☐3 OK
☐4 Comfortable
☐5 Very Comfortable *24*

12.) When seeing under 16s about sexual health, do you provide them with written materials?

☐1 Always
☐2 Usually
☐3 Sometimes
☐4 Rarely
☐5 Never *25*

13.) Does your practice provide any special services for teenagers?

☐1 No *26* *27*
☐2 Yes **Please describe:** _____

14.) What proportion of young people do you think have sex before they are 16 years old? ☐ % *28-29*

15.) The following form the Gillick ruling on under 16s treatment:

Doctors treating under 16s should:

- Judge whether the patient understands the potential risks and benefits of any treatment given.
- Emphasise the value of parental support and try to persuade the patient to inform, or let them inform, their parents.
- Reassure the patient that if they do not want their parents involved, confidentiality will be respected.
- Make a judgement as to whether or not the young person is likely to start or continue having sex whether or not the doctor provides contraception.
- Assess whether the patient's mental or physical health is likely to suffer if they do not receive contraceptive supplies.
- Consider whether the patient's best interests would require the provision of contraceptive supplies.

16.) Are you uncomfortable with any aspect of these provisions? ☐1 Yes ☐2 No *30*

Why? _____ *21-22*

_____

17.) Please use the space below to add any comments you have about treating the under 16s for sexual health:

_____ *33-34*

_____

School survey questionnaire
NOTES FOR QUESTIONNAIRE ADMINISTRATOR:

1. Please reassure all pupils that this questionnaire will not be seen by anyone at the school - it will be sealed in an envelope and opened by a researcher at the University of Exeter. The school will see the results as a whole but all their individual answers are anonymous and confidential. They should NOT put names on the paper.

2. The questions seek information about what they know about sex, contraception, sexually transmitted diseases and local services. There are also some personal questions about them and sex - we know that most of them will not have had sex, but research suggests that a few will have. These questions are being asked because we want to know what could be improved. IT IS NOT A TEST. The information provided will help us to see what information they need and what services they might wish to use.

3. All pupils should feel free not to answer questions if they prefer not to - if a question is not relevant to them they can tick the box which says "This does not apply to me".

4. Most of the questions are just a tick box but please look out for extra bits which explain an answer eg Ques 7. "say who" or Ques. 23 "say where".

5. Ignore the little numbers next to tick boxes - these are so the questionnaire can be analysed.

6. For questions 15-22 "Neutral" means you don't agree or disagree with the statement but have no feelings about it either way.

7. Ques. 33 - 39 "sex" means full sexual intercourse - that is the penis entering the vagina.

8. After they have finished, (before will give away some of the answers!) remind them that they can talk to their doctor, Family Planning Clinic or school nurse about any issues raised that might concern them in complete confidence.

9. For information, answers to the factual questionnaire are as below.

Ques. 11-15 Anyone can get confidential sexual health services from an FPC - under 16s too.
The nearest Family Planning Clinic is in xxxxxxx hospital open Wed. 6- 8:30pm
xxxxxxxx no longer has a clinic.
xxxxxxxx FPC is in xxxxxxxx Hill (near the xxxxxxx swimming pool) and is open Mon - Fri (all day plus eve. but times vary) plus Sat. am

Ques. 17-18 xxxxxxxx Teenage Advice Clinic is open every Thursday 4:30-5:30 pm

Ques. 27 Free condoms are available from some GPs, Family Planning Clinics, the xxxxxxxx Teenage Advice Clinic, usually the school nurse and youth workers.

Ques. 28 STDs = Herpes, HIV, Chalmydia, Syphilis, Trichomonas, Warts, Gonorrhoea (Plasmodium = parasitic disease of red blood cells eg Malaria, Filaria = Tiny worm. Can live in small lymph vessels causing elephantiasis.)

Ques. 29 False many STDs are symptomless, especially in the early stages - eg. chlmaydia, and also HIV. No outside signs to give it away!

Ques. 30 False. Genital warts are the most common STD in the UK, followed by chlamydia.

Ques. 31 True Since the Gillick ruling more than 10 years ago, it has been the law that doctors and clinics owe the same duty of confidentiality to under 16s as to over 16s.

Ques. 32 True Emergency contraception (EC) is effective for up to 72 hrs (3 days) after unprotected sexual intercourse.

Ques. 33 True There is no evidence that it is not safe to use EC more than once. However, since it is less effective than other forms of contraception it may be better to change to a more effective contraception eg. pill, injection etc if you are having sex regularly. About half of women feel nauseous taking EC and about 20% will vomit -as well as being unpleasant, this may reduce the effectiveness of EC.

Ques. 34 False Used consistently and correctly a condom is 98% effective, and additionally protects against STDs. Evidence for the effectiveness of EC is complex but it is believed to be between 95% and 98% effective, other studies suggest it will prevent 3 out of 4 pregnancies that would have otherwise occurred if used once in a cycle. It can cause nausea and is not really suitable as a regular contraceptive method.

Ques. 35 False Based on a 28 day menstrual cycle, with day 1 being the first day of a period, ovulation occurs on day 14. Therefore a week after the period in the MOST fertile time - remember that studies suggest sperm can lurk for up to 5 days!

Ques. 36 True The pill is thought to protect against some kinds of cancer of the womb.

Notes for those completing questionaire

Thank you for your help in completing this questionnaire

Please be as honest as you can when completing this questionnaire.

This is not a test – we are interested to find out what you know only so that we know what information you still need to be given.

Feel free to leave any questions you would rather not answer - if they do not apply to you, you should tick the box which says: "This does not apply to me".

At the end of the session, please put your completed questionnaire into the envelope provided and seal it. It will be opened and analysed at Exeter University.
Please do not put your name on the paper - the questionnaire is anonymous.
Nobody in school will see the completed forms so your answers will be strictly confidential. Your finished questionnaire will only be seen by a researcher at the University of Exeter who will report to the school.
Your answers cannot be traced back to you.

We would like to improve the health services currently offered for teenagers in and around Brownton so your views are important.

Questionnaire

1. How old are you: _____ years

2. Are you: ☐1 Male ☐2 Female

3. Which Year are you in school? Year _____

4. Have you been to see a doctor since Christmas? ☐1 No
☐2 Yes, once
☐3 Yes, more than once

5. Do you know the name of your own doctor? ☐1 Yes
☐2 No

6. Where is your doctor's surgery:
☐1 in the town/village where you live
☐2 less than 5 miles from where you live
☐3 more than 5 miles from where you live
☐4 I don't know where my doctor's surgery is

7. Who usually makes the appointment when you go to the doctor?
☐1 Me
☐2 My mum
☐3 My dad
☐4 Other - Say who:

8. How would you normally get to the doctor's surgery?
☐1 Walk
☐2 Get a lift -with who?
☐3 Get the bus
☐4 Other - say how:

9. Have you ever been to the doctor's surgery without a parent or guardian?
☐1 No
☐2 Yes, once
☐3 Yes, more than once

10. What is a Family Planning Clinic? (Tick the one which best says what it does)

☐1 Somewhere anyone can get contraception and sexual health services
☐2 Somewhere young families can go for advice
☐3 Somewhere to get milk tokens and other benefits for babies
☐4 Somewhere married people go for contraception and sexual health services

11. Where is the nearest Family Planning Clinic? _____ or ☐1 Don't know
12. What day(s) is it open? _____ or ☐1 Don't know
13. What time is it open? _____ or ☐1 Don't know

14. Have you heard of the Teenage Advice Clinic in Hemyock?
☐1 Yes
☐2 No - Go to question 17

15. What day is it open? _____ or ☐1 Don't know

16. What time is it open? _____ or ☐1 Don't know

SAY IF YOU AGREE, DISAGREE OR ARE NEUTRAL (DON'T AGREE OR DISAGREE) ABOUT THE FOLLOWING STATEMENTS:

17. My doctor is someone I could talk to if I was worried about anything

□1 Agree □2 Neutral □3 Disagree □4 Don't Know

18. I would trust my doctor to keep anything that I say confidential
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

19. I think my doctor would treat me with respect, whatever I came in for
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

20. Getting a quick appointment at the doctors is difficult
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

21. If possible, I would prefer to see a nurse rather than a doctor about my problems
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

22. If possible, I would prefer to see a doctor/GP who is the same sex as me
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

23. If I talk to the school nurse about anything to do with sex she might tell my teachers.
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

24. I would feel embarrassed talking to a school nurse about sex
□1 Agree □2 Neutral □3 Disagree □4 Don't Know

25. Do you know anywhere where you can get free condoms? □1 No
□2 Yes -say where _____

26. Tick ALL of the following which you think are sexually transmitted diseases:

□Plasmodium	□Chlamydia	□Trichomonas
□Herpes	□Filaria	□Warts
□HIV	□Syphilis	□Gonorrhoea

SAY IF YOU THINK THE FOLLOWING STATEMENTS ARE TRUE OR FALSE:

27. You would be able to tell if you had a sexually transmitted disease
□1 True □2 False □3 Don't Know

28. HIV/AIDS is the most common sexually transmitted disease in the UK
□1 True □2 False □3 Don't Know

29. Teenagers under 16 can get contraception from their doctor or a clinic without their parents being told
□1 True □2 False □3 Don't Know

30. If you have sex without using contraception on Friday night you can still use Emergency Contraception/the Morning After Pill on Monday morning.
□1 True □2 False □3 Don't Know

31. It is safe to take Emergency Contraception/the Morning After Pill more than 3 times a year.
□1 True □2 False □3 Don't Know

32. Taking Emergency Contraception/the Morning After Pill is as good at preventing pregnancy as using a condom.

□1 True □2 False □3 Don't Know

33. Taking the pill can protect women against some kinds of cancers
□1 True □2 False □3 Don't Know

FOR THE FOLLOWING QUESTIONS 'SEX' MEANS FULL SEXUAL INTERCOURSE - THAT IS THE PENIS ENTERING THE VAGINA

34. Have you had sex yet? □1 No □2 Yes □3 I'd rather not say

35. How old were you the first time you had sex?:

□1 I haven't had sex yet □2 I'd rather not say
□3 less than 13 □4 13 □5 14 □6 15 □7 16

36. How old was your partner the first time you had sex?
□01 This question doesn't apply to me

or……years

37. Do you or your partner usually use contraception when you have sex?

□1 This question , □2 No □3 Yes What do you use?

_____
doesn't apply to me

38. How often have you had sex without contraception?
□1 This question doesn't apply to me - Go to question 41
□2 Never - Go to question 41
□3 Rarely
□4 Sometimes
□5 Often

39. Why do you sometimes have sex without contraception?

_____

40. How many people have you had sex with, in total?

□1 This question doesn't apply to me □2 1 □3 2 □4 3 □5 4+

41. Have you (or a partner) ever used Emergency Contraception / Morning after Pill?

□1 This question doesn't apply to me
□2 Yes How many times? _____
□3 No
□4 Don't know

42. Have you ever been to the doctor (GP) for contraception or other sexual health matter, including period problems or concerns about body changes?

☐1 No
☐2 Yes- what did you go for most recently? _____

43. Have you ever been to a Family Planning Clinic (FPC) for contraception or other sexual health matter including period problems or concerns about body changes?

☐1 No
☐2 Yes - what did you go for most recently? _____
- Which FPC did you go to? _____

44. Have you ever been to the Brownton Teenage Advice Clinic for contraception or other sexual health matter including period problems or concerns about body changes?

☐1 No
☐2 Yes- what did you go for most recently? _____

45. Have you ever been to the School Nurse for advice about contraception or other sexual health matter including period problems or concerns about body changes?

☐1 No
☐2 Yes- what did you go for most recently? _____

46. Have you ever spoken to a Youth Worker about contraception or other sexual health matter including period problems or concerns about body changes?

☐1 No
☐2 Yes- what did you go for most recently? _____

47. Please use the space below to make any comments you may have about getting information and services, about sex or contraception: about doctors, Family Planning Clinics, school nurses, local services for teenagers, youth workers, sex education or any other issues you think are important.

These are presented in the tables below. All show percentages. Chi square results and p values are also given.

RESULTS - USE OF THE GP

Where is your doctor's surgery?

	Year 9 (n=311)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
In your town/village	46.3	45.5	47.0	47.1	53.0	39.6	46.4
< 5 miles from home	32.5	33.1	31.9	35.3	31.8	39.6	33.2
> 5 miles from home	20.6	20.7	20.5	16.8	15.2	18.9	19.7
Don't know	0.6	0.7	0.6	0.8	0.0	1.9	0.7

For Year 11 by Sex Chi square =3.117, DF = 3, p = 0.374
For Year 9 by Sex Chi square = 0.080, DF = 3, p = 0.994
For Boys & Girls by Year Chi square = 0.994, DF = 3, p = 0.803

Do you know the name of your doctor?

	Year 9 (n=309)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Yes	89.6	91.7	87.9	79.8	89.4	67.9	86.9
No	10.4	8.3	12.1	20.2	10.6	32.1	13.1

For Year 9 by Sex Chi square = 1.188, DF = 1, p = 0.276 For Year 11 by Sex Chi square = 8.415, DF = 1, p = 0.004* For Boys & Girls by Year Chi square = 7.344, DF = 1, p = 0.007

Have you seen your doctor since Christmas?

	Year 9 (n=308)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
No	36.0	28.3	42.9	47.1	39.4	56.6	39.0
Yes, once	38.3	41.4	35.6	30.3	30.3	30.2	36.2
Yes, more than once	25.6	30.3	21.5	22.7	30.3	10.6	24.8

For Year 11 by Sex Chi square = 5.636, DF = 2, p = 0.060
For Year 9 by Sex Chi square = 7.610, DF = 2, p = 0.022
For Boys & Girls by Year Chi square = 4.636, DF = 2, p = 0.098

Who usually makes an appointment when you go to the doctor?

	Year 9 (n=308)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Me	14.9	18.1	12.2	31.1	42.4	17.0	19.4
Parent/Guardian	85.1	81.9	87.8	68.9	57.6	83.0	80.6

For Year 9 by Sex Chi square = 2.073, DF = 1, p = 0.150
For Year 11 by Sex Chi square = 8.882, DF = 1, p = 0.003*
For Boys & Girls by Year Chi square = 14.434, DF = 1, p < 0.005*

How would you normally get to the Doctor's surgery?

	Year 9 (n=308)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Walk/cycle	36.7	32.9	40.0	39.5	51.5	24.5	36.7
Get a lift	63.3	67.1	60.0	60.5	48.5	75.5	62.6

For Year 9 by Sex Chi square = 10.678, DF = 1, p = 0.195
For Year 11 by Sex Chi square = 8.958, DF = 1, p = 0.003*
For Boys & Girls by Year Chi square = 7.911, DF = 2, p = 0.019*

Have you ever been to see your doctor on your own?

	Year 9 (n=311)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
No	51.8	57.2	47.0	31.9	30.3	35.8	46.4
Yes - once	19.6	19.3	19.9	20.2	21.2	17.0	19.7
Yes - more than once	28.6	23.4	33.1	47.9	48.5	47.2	33.9

For Year 9 by Sex Chi square = 4.121, DF = 2, p = 0.127
Year 11 by Sex Chi square =0.55875, DF = 2, p 0.756
Girls by Year Chi square = 16.140, DF =2, p<0.005*

For
For Boys &

RESULTS - KNOWLEDGE OF LOCAL SEXUAL HEALTH SERVICES

What is a Family Planning Clinic?

	Year 9 (n=306)			Year 11 (n=115)			
	All	Girls	Boys	All	Girls	Boys	All
Somewhere anyone can get contraception and sexual health services	63.7	66.9	61.0	74.8	79.9	66.7	66.0
Somewhere young families can go for advice	30.7	28.9	32.3	20.9	17.2	27.4	28.2
Somewhere to get milk tokens and other benefits for babies	0.0	0.0	0.0	1.7	1.6	2.0	4.7
Somewhere married people can get contraception and sexual health services	5.6	4.2	6.7	2.6	1.6	3.9	4.7

For Year 9 correct response by Sex Chi square = 1.557, DF = 2, p = 0.459
For Year 11 correct response by Sex Chi square = 2.658, DF = 3, p = 0.447
For Boys & Girls correct response by Year Chi square = 10.467, DF = 3, p = 0.015

Where is the nearest Family Planning Clinic?

	Year 9 (n=311)			Year 11 (n= 119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Don't know	74.0	73.1	74.7	54.6	39.3	75.5	68.7
Redton	6.0	4.1	5.1	5.9	7.6	1.9	5.1
Orangeville	7.8	8.3	8.0	21.0	31.8	7.4	11.8
Pinkham	3.0	5.5	4.2	10.9	10.6	11.3	6.0
Brownton	3.6	4.1	3.9	3.4	6.1	0.0	3.7
Limeton	1.2	2.1	1.6	2.5	3.0	1.9	1.9
GP surgery	1.8	0.0	1.0	0.8	1.5	0.0	0.9
Other	1.8	2.8	2.3	0.8	0.0	1.9	1.9

For Year 9 correct response by Sex Chi square = 5.089, DF = 7, P = 0.649 For Year 11 correct response by Sex Chi square =22.454, DF = 7, p = 0.002*
For Boys & Girls correct response by Year Chi square = 23.772, DF = 7, p = 0.001*

What day is the FPC open?

	Year 9 (n=310)			Year 11 (n=116)			
	All	Girls	Boys	All	Girls	Boys	ALL
Don't Know	92.9	90.3	95.2	92.2	88.9	96.2	92.7
Wrong	4.5	5.5	3.6	4.3	6.3	1.9	4.4
Largely correct	1.3	2.1	0.6	0.9	1.6	0.0	1.2
Correct	1.3	2.1	0.6	2.5	3.2	1.9	1.6

For Year 9 by Sex Chi square = 3.357, DF = 3, P = 0.340
For Year 11 by Sex Chi square = 2.524, DF = 3, p = 0.471
For Boys & Girls by Year Chi square = 1.012, DF = 3, p = 0.798

What time is the FPC open?

	Year 9 (n=310)			Year 11 (n=117)			
	All	Girls	Boys	All	Girls	Boys	ALL
Don't Know	96.8	96.5	97.0	95.7	95.3	96.2	96.5
Wrong	1.6	0.7	2.4	2.6	3.1	1.9	1.9
Largely correct	0.6	0.7	0.6	0.9	1.6	0.0	0.7
Correct	1.0	2.1	0.0	0.9	0.0	1.9	0.9

For Year 9 by Sex Chi square = 4.877, DF = 3, p = 0.181
For Year 11 by Sex Chi square = 2.212, DF = 3, p = 0.530
For Boys & Girls by Year Chi square = 0.491, DF = 3, p = 0.921

Have you heard of the Teenage Advice Clinic in Brownton

	Year 9 (1999)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
Yes	51.0	61.1	41.8	51.7	59.1	40.4	44.7
No	49.0	38.9	58.2	48.3	40.9	59.6	55.3

For Year 9 by Sex Chi square = 5.637, DF = 1, p = 0.018*
For Year 11 by Sex Chi square = 4.072, DF = 1, p = 0.044*
For Boys & Girls by Year Chi square = 2.526, DF = 1, p = 0.112

What day is the TAC open?

	Year 9			Year 11			
	All	Girls	Boys	All	Girls	Boys	ALL
Don't Know	82.2	77.6	87.8	82.6	78.0	88.9	82.8
Thursday	7.8	8.2	7.3	11.6	14.0	8.3	9.5
Other day stated	10.0	14.2	4.9	5.9	8.0	2.8	7.6

For Year 9 by Sex Chi square = 2.281, DF = 2, p = 0.320
For Year 11 by Sex Chi square = 1.860, DF = 2, p = 0.394
For Boys & Girls by Year Chi square = 1.641, DF = 2, p = 0.44

What time is TAC open?

	Year 9 (n=90)			Year 11 (n=84)			
	All	Girls	Boys	All	Girls	Boys	ALL
Don't Know	90.0	87.8	92.7	85.7	83.3	88.9	89.9
Wrong	2.2	2.0	2.4	4.8	4.2	5.6	2.6
Largely correct	1.1	2.0	0.0	4.8	6.2	2.8	2.2
Correct	6.7	8.2	4.9	4.8	6.2	2.8	5.3

For Year 9 by Sex Chi square = 1.274, DF = 3, p = 0.735 For Year 11 by Sex Chi square = 1.200, DF = 3, p = 0.753 For Boys & Girls by Year Chi square = 6.620, DF = 3, p =0.08

Do you know anywhere you can get free condoms

	Year 9 (n=306)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
No	59.8	58.5	61.0	32.2	26.1	39.6	52.2
Yes	40.2	41.5	39.0	67.8	73.9	60.0	47.8

For Year 9 by Sex Chi square = 0.202, DF = 1, p = 0.6530
For Year 11 by Sex Chi square = 2.426, DF = 1, p = 0.119
For Boys & Girls by Year Chi square = 26.273, DF = 1, p < 0.005*

RESULTS - ATTITUDES TOWARDS HEALTH PROFESSIONALS

Pupils were asked to indicate whether they agreed, disagreed were neutral or didn't know about a series of statements concerning attitude towards various health professionals and services. The titles show the form of the statements used in the questionnaires

My doctor is someone I could talk to if I was worried about anything

	Year 9 (n=311)			Year 11 (n=95)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	40.5	31.0	48.8	49.5	40.9	37.7	42.5
Neutral	28.0	27.6	28.3	28.4	18.2	28.3	28.3
Disagree	18.0	24.8	12.0	15.8	15.2	9.4	17.4
Don't know	13.5	16.6	10.8	6.3	7.6	1.9	11.8

Agreed for Year 9 by Sex Chi square = 14.928, DF = 3, p = 0.002*
Agreed for Year 11 by Sex Chi square = 4.005, DF = 3, p = 0.261
Agreed for Boys & Girls by Year Chi square = 4.764, DF = 3, p = 0.190

I would trust my doctor to keep anything I say confidential

	Year 9 (n=311)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	71.1	64.1	77.1	78.2	78.8	77.3	72.9
Neutral	13.5	17.9	9.6	6.7	7.6	5.7	11.6
Disagree	8.4	9.0	7.8	7.6	6.1	9.4	8.4
Don't know	7.1	9.0	5.4	7.6	7.6	7.5	7.2

For Year 9 by Sex Chi square = 7.266, DF = 3, p = 0.64
For Year 11 by Sex Chi square = 0.610, DF = 3, p = 0.894
For Boys & Girls by Year Chi square = 4.159, DF = 3, p = 0.245

I think my doctor would treat me with respect whatever I came in for

	Year 9 (n=308)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	70.1	62.7	76.5	71.4	71.2	71.7	70.3
Neutral	19.2	21.8	16.9	15.1	16.7	13.2	18.2
Disagree	5.8	9.9	2.4	5.9	4.5	7.5	5.8
Don't know	4.9	5.6	4.2	7.6	7.6	7.5	5.6

For Year 9 by Sex Chi square = 10.655, DF = 3, p = 0.014*
For Year 11 by Sex Chi square = 0.684, DF = 3, p = 0.877
For Boys & Girls by Year Chi square = 2.021, DF = 3, p = 0.568

Getting a quick appointment at the doctors is difficult

	Year 9 (n=309)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	32.0	33.3	30.9	41.2	40.9	41.5	34.5
Neutral	39.5	38.9	40.0	31.9	31.8	32.1	37.5
Disagree	17.8	18.1	17.6	18.5	18.2	18.9	17.9
Don't know	10.7	9.7	11.5	8.4	9.1	7.5	10.0

For Year 9 by Sex Chi square = 0.406, DF = 3, p = 0.939
For Year 11 by Sex Chi square = 0.094, DF = 3, p = 0.992
For Boys & Girls by Year Chi square = 3.961, DF = 3, p = 0.266

If possible, I would prefer to see a nurse rather than a doctor about my problems

	Year 9 (n=310)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	31.3	57.9	7.9	33.1	45.4	17.3	31.9
Neutral	33.2	27.6	38.2	33.9	32.8	32.7	33.3
Disagree	28.4	9.0	45.5	25.4	9.1	46.2	27.5
Don't know	7.1	5.5	8.5	7.6	10.6	3.8	7.2

For Year 9 by Sex Chi square = 101.556, DF = 3, p < 0.005*
For Year 11 by Sex Chi square = 24.469, DF = 3, p < O.OO5*
For Boys & Girls by Year Chi square = 0.372, DF = 3, p = 0.946

If possible, I would prefer to see a doctor/GP who is the same sex as me

	Year9 (n=311)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	62.1	77.2	48.8	52.1	57.6	45.3	59.4
Neutral	26.0	15.9	34.9	35.3	31.8	39.6	28.5
Disagree	8.7	4.1	12.7	6.7	4.5	9.4	8.1
Don't know	3.2	2.8	3.6	5.9	6.1	5.7	3.9

For Year 9 by Sex Chi square = 27.544, DF = 3, p < 0.005*
For Year 11 by Sex Chi square = 2.413, DF = 3, p = 0.491
For Boys & Girls by Year Chi square = 6.063, DF = 3, p = 0.109

If I talk to the school nurse about anything to do with sex, she might tell my teachers

	Year 9 (n=310)			Year 11 (n=117)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	16.1	17.9	14.5	9.4	9.1	9.8	14.3
Neutral	16.8	15.2	18.2	12.0	10.6	13.7	15.4
Disagree	51.9	52.4	51.5	62.4	66.7	55.8	54.9
Don't know	15.2	14.5	15.8	16.2	13.6	19.6	15.4

For Year 9 by Sex Chi square = 1.060, DF = 3, p = 0.787
For Year 11 by Sex Chi square = 1.324, DF = 3, p = 0.723
For Boys & Girls by Year Chi square = 5.618, DF = 3, p = 0.132

I would feel embarrassed talking to the school nurse about sex

	Year 9 (n=309)			Year 11 (n=117)			
	All	Girls	Boys	All	Girls	Boys	ALL
Agree	43.7	41.0	46.1	32.5	21.5	46.2	40.7
Neutral	27.8	29.9	26.1	23.9	23.1	25.0	26.7
Disagree	21.0	22.2	20.0	33.3	44.6	19.2	24.4
Don't know	7.4	6.9	7.9	10.3	10.8	9.6	8.2

For Year 9 by Sex Chi square = 1.125, DF = 3, p = 0.771
For Year 11 by Sex Chi square = 11.056, DF = 3, p = 0.011*
For Boys & Girls by Year Chi square = 9.334, DF = 3, p = 0.025

RESULTS - KNOWLEDGE

A series of questions were asked which aimed to establish pupil's level of knowledge about Sexually Transmitted Infections (STIs), Emergency Contraception (EC), and contraceptives. Most were in a True or False format, with an additional "Don't know" category. A list of conditions, some STIs and some not, was given and respondents were asked to tick those that they thought were STIs. Results are shown in Table 55. (correct answers are given in below)

Table 55: Percentage of respondents identifying those listed as STIs

	Year 9 (n=151)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Plasmodium	14.5	15.9	13.3	2.5	3.0	1.9	11.1
Herpes	53.1	52.4	53.6	73.9	75.8	71.7	58.9
HIV	97.1	97.2	97.0	98.3	100.0	96.2	97.4
Chlamydia	38.9	41.4	36.7	18.5	22.7	13.2	33.4
Filaria	20.6	17.9	22.9	8.4	4.5	13.2	17.2
Syphilis	44.4	45.5	43.4	46.2	47.0	45.3	44.8
Trichomonas	19.3	18.6	19.9	6.7	6.1	7.5	15.8
Warts	29.6	36.6	23.5	42.9	50.0	34.0	33.4
Gonorrhoea	51.8	51.0	52.4	56.3	53.0	60.4	53.1

For Year 9 difference between the sexes p > 0.05
For Year 11 difference between the sexes p >0.05

You would be able to tell if you had a sexually transmitted disease

	Year 9 (n=310)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	15.8	19.3	12.7	20.3	15.4	26.4	17.0
False	59.4	53,8	64.2	60.2	60.0	60.4	59.7
Don't know	24.8	26.9	23.0	19.5	24.6	13.2	23.3

For Year 9 by Sex Chi square = 4.000, DF = 2, p = 0.135
For Year 11 by Sex Chi square = 3.696, DF = 2, p = 0.157
For Boys & Girls by Year Chi square = 2.081, DF = 2, p = 0.353

HIV/AIDS is the most common sexually transmitted disease in the UK

	Year 9 (n=311)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	54.0	55.2	53.0	42.4	36.9	49.1	50.7
False	29.3	29.7	28.9	33.1	40.0	24.5	30.5
Don't Know	16.7	15.2	18.1	24.6	23.1	26.4	18.8

For Year 9 by Sex Chi square = 0.471, DF = 2, p = 0.790
For Year 11 by Sex Chi square = 3.261, DF = 2, p = 0.196
For Boys & Girls by Year Chi square = 5.424, DF = 2, p <0.005

Teenagers under 16 can get contraception from their doctor or clinic without their parents being told

	Year 9 (n==311)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	64.3	60.7	67.5	66.9	60.0	75.5	65.1
False	15.8	17.2	14.5	13.6	12.3	15.1	15.1
Don't Know	19.9	22.1	18.1	19.5	27.7	9.4	19.8

For Year 9 by Sex Chi square = 1.554, DF = 2, p = 0.460
For Year 11 by Sex Chi square = 6.204, DF = 2, p = 0.045*
For Boys & Girls by Year Chi square = 0.351, DF = 2, p = 0.839

If you have sex without using contraception on Friday night you can still use Emergency Contraception/the 'morning after pill' on Monday morning

	Year 9 (n=308)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	50.3	60.4	41.5	58.5	63.1	52.8	52.7
False	30.2	25.7	34.1	27.1	29.2	24.5	29.3
Don't Know	19.5	13.9	24.4	14.4	7.7	22.6	18.0

For Year 11 by Sex Chi square = 5.291, DF = 1, p = 0.071
For Year 9 by Sex Chi square = 11.628, DF = 2, p = 0.003*
For Boys & Girls by Year Chi square = 2.482, DF = 2, p = 0.289

It is safe to use EC more than 3 times a year

	Year 9 (n=309)			Year 11 (n=117)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	26.2	22.1	29.9	28.2	36.9	17.0	26.9
False	15.9	15.2	16.5	11.1	10.8	11.3	14.5
Don't Know	57.9	62.8	53.7	60.7	52.3	69.8	58.5

For Year 9 by Sex Chi square = 2.971, DF = 2, p = 0.226
For Year 11 by Sex Chi square = 5.647, DF = 2, p = 0.059
For Boys & Girls by Year Chi square = 1.512, DF = 2, p = 0.469

Taking EC is as good at preventing pregnancy as using a condom

	Year 9 (n=310)			Year 11 (n=116)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	21.3	28.3	15.2	21.6	22.7	18.9	21.5
False	59.7	51.0	67.3	51.7	48.5	52.8	57.4
Don't Know	19.0	20.7	17.6	26.7	27.3	25.5	21.1

Boys & Girls by Year Chi square = 3.297, DF = 2, p = 0.192
For Year 9 by Sex Chi square = 10.047, DF = 2, p = 0.007*
For Year 11 by Sex Chi square = 0.389, DF = 2, p = 0.823

Taking the pill can protect against some kinds of cancer

	Year 9 (n=309)			Year 11 (n=118)			
	All	Girls	Boys	All	Girls	Boys	ALL
True	12.2	8.3	15.7	10.2	13.8	5.7	11.6
False	46.0	49.7	42.8	48.3	49.2	47.2	46.7
Don't know	41.8	42.1	41.6	41.5	36.9	47.2	41.6

For Year 9 by Sex Chi square = 4.259, DF = 2, p = 0.119
For Year 11 by Sex Chi square = 2.687, DF = 2, p = 0.261
For Boys & Girls by Year Chi square = 0.383, DF = 2, p = 0.826

RESULTS - SEXUAL BEHAVIOUR AND USE OF SERVICES

Questions were asked about respondents' sexual behaviour and use of services for sexual health matters. After consultation with the school it was agreed that all the questions relating to sexual behaviour included both a box to tick which said "This question doesn't apply to me", and also a box for "I'd rather not say." This was with the aim of ensuring all pupils answered all the questions (which would avoid the sexually active taking longer to complete the questionnaire.) The "Rather not say" box also allowed privacy for those not wanting to provide this information

Have you had sex yet?

	Year 9 (n=310)			Year 11 (n=119)			
	All	Girls	Boys	All	Girls	Boys	ALL
Yes	16.5	18.1	15.1	42.0	53.0	28.3	23.5
No	75.8	79.2	72.9	52.9	40.9	67.9	69.5
I'd rather not say	7.7	2.8	12.0	5.0	6.1	3.8	7.0

For Year 9 by Sex Chi square = 9.381, DF = 2, p =0.009*
For Year 11 by Sex Chi square = 8.635, DF = 2, p = 0.013*
For Boys & Girls by Year Chi square = 31.446, DF = 2, p < 0.005*

How old were you the first time you had sex? (Number and %)

	Year 9 (n==72)			Year 11 (n=54)			
	All	Girls	Boys	All	Girls	Boys	ALL
Rather not say	24(33.3)	6(20.0)	18(42.9)	7(13.0)	5(12.8)	2(13.3)	31 (24.6)
<13	9(12.5)	4(13.3)	5(11.9)	2(3.7)	2(5.1)	0(0.0)	11(8.7)
13	19(26.4)	12 (40.0)	7 (16.7)	7(13.0)	6(15.4)	1(6.7)	26 (20.6)
14	20(27.8)	8 (26.7)	12 (28.6)	11(20.4)	7(17.9)	4(26.7)	31 (24.6)
15	x	x	x	20 (37.0)	14 (35.9)	6 (40.0)	20 (15.9)
16	x	x	x	7(13.0)	5(12.8)	2(13.3)	7 (5.6)

For Year 9 by Sex Chi square = 6.405, DF = 3, p = 0.093
For Year 11 by Sex Chi square = 2.687, DF = 2, p = 0.261
For Boys & Girls by Year Chi square = 47.323, DF = 5, p < 0.005*

As well as being asked how old they were when they had sex, sexually active respondents were asked the age of their partner the first time they had sex

Age difference with partner at first sex -Number (%)

	Year 9 (n=21)			Year 11 (n=40)			
	All	Girls	Boys	All	Girls	Boys	ALL
1 year younger	0 (0)	0 (0)	0 (0)	2(5.0)	1(3.2)	1(11.1)	2 (3.3)
Same age	4(19.0)	3(25.0)	1(11.1)	12 (30.0)	8 (25.8)	4 (44.4)	16 (26.2)
1 year older	6(28.6)	3(25.0)	3(33.3)	7(17.5)	6(19.4)	1(11.1)	13 (21.3)
2 years older	6(28.6)	3(25.0)	3(33.3)	6 (15.0)	3 (9.7)	3 (33.3)	12 (19.7)
3 years older	3 (14.3)	1 (8.3)	2(22.2)	6(15.0)	6(19.4)	0(0)	9 (14.7)
4 years older	1(4.8)	1(8.3)	0 (0)	2 (5.0)	2 (6.4)	0 (0)	3 (4.9)
5 years older	0 (0)	0 (0)	0 (0)	2 (5.0)	2 (6.4)	0 (0)	2(3.3)
6 years older	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0.0)
7 years older	1 (4.8)	1 (8.3)	0 (0)	1 (2.5)	1 (3.2)	0 (0)	2 (3.3)
12 years older	0 (0)	0 (0)	0 (0)	1 (2.5)	1 (3.2)	0 (0)	1 (1.6)
13 years older	0 (0)	0 (0)	0 (0)	1(2.5)	1(3.2)	0(0)	1(1.6)

Do you or your partner usually use contraception when you have sex? Number (%)

	Year 9 (n=50)			Year 11 (n=49)			
	All	Girls	Boys	All	Girls	Boys	ALL
No	11(22.0)	6(25.0)	5(19.2)	4(8.2)	4(11.4)	0	15(15.2)
Pill	5 (10.0)	1 (4.2)	4 (15.4)	6(12.2)	4(11.4)	2(14.3)	11(11.1)
Condom	24(48.0)	12(50.0)	12(46.2)	27(55.1)	19(54.3)	8(57.1)	51(51.5)
Condom plus	7(14.0)	3(12.5)	4(15.4)	8(16.3)	7(20.0)	1(7.1)	15(15.1)
Yes (no details)	3 (6.0)	2 (8.3)	1 (3.8)	4(8.2)	1(2.9)	3(21.4)	7(7.1)

How often do you have sex without contraception? Number (%)

	Year 9 (n=53)			Year 11 (n= 50)			
	All	Girls	Boys	All	Girls	Boys	ALL
Never	19(35.8)	7 (28.0)	12(42.9)	30(60.0)	19(54.3)	11(73.3)	49(47.6)
Rarely	20(37.7)	11(44.0)	9(32.1)	8 (16.0)	5 (14.3)	3 (20,0)	28(27.2)
Sometimes	10(18.9)	6(24.0)	4(14.3)	8 (16.0)	7 (20.0)	1 (6.7)	18(17.5)
Often	4 (7.5)	1 (4.0)	3 (10.7)	4(8.0)	4(11.4)	0(0.0)	8(7.8)

How many people have you had sex with in total? Number (%)

	Year 9 (n=50)			Year 11 (n= 42)			
	All	Girls	Boys	All	Girls	Boys	ALL
1	24(48.0)	14(56.0)	10(40.0)	13(31.0)	9(30.0)	4(33.3)	38(43.7)
2	6 (12.0)	2 (8.0)	4 (16.0)	11(26.2)	7(23.3)	4(33.3)	12(13.8)
3	7 (14.0)	4 (16.0)	3 (12.0)	4(9.5)	3(10.0)	1(8.3)	(1112.6)
4+	13(26.0)	5 (20.0)	8 (32.0)	14(33.3)	11(36.7)	3(25.0)	26(29.9)

Table 69: Have you or a partner ever used EC? Number (%)

	Year 9 (n=57)			Year 11 (n=51)			
	All	Girls	Boys	All	Girls	Boys	ALL
Yes	20(35.1)	13(46.4)	7(24.1)	12(23.5)	10(27.8)	2 (13.3)	32(29.6)
No	32(56.1)	15(53.6)	17(58.6)	36(70.6)	26(72.2)	10(66.7)	68(63.0)
Don't Know	5(8.8)	0(0.0)	5(17.2)	3 (5.9)	0 (0.0)	3 (20.0)	8(7.4)

Appendix 5

CONFIDENTIAL SURVEY FOR TEENAGERS

Section One: About You 11

1. **Are you:** ☐1 Female ☐2 Male **2. Age:** ☐☐ Years

3. **Are you:** ☐ At school → **Year** ☐☐
(Tick all that apply) ☐ At school - in the sixth form
☐ At college
☐ At university
☐ Employed – part time
☐ Employed – full time
☐ Looking for work
☐ Full time mother / housewife
☐ Other - **say what:** _____

4. **Marital Status:** ☐1 Single ☐3 Married ☐2 Living together ☐4 Divorced/Separated

5. **Number of Children:** ☐1 None ☐2 One ☐3 Two or more 27

Section Two: About Your Use of your GP and Other Services 30-31

6. **What have you come to your doctor about today?** _____

7. **Have you come:** ☐ Alone
(Tick all that apply) ☐ With a friend
☐ With your boyfriend or girlfriend
☐ With a parent
☐ Other -**please say who**: _____

8. **Who made the appointment for you to see the doctor today? (Tick one only)**
☐1 I did
☐2 My mum did
☐3 My dad did
☐4 A friend did
☐5 I didn't have an appointment
☐6 Other - **please write who**: _____

9. **How did you get to the doctors' surgery today?**

☐1 Walked
☐2 Cycled
☐3 Got a lift → **Who with?** ☐1 Parent ☐2 Friend ☐3 Other - say who: _____
☐4 Drove myself
☐5 Took the bus
☐6 Other (please say how) _____
42

CONFIDENTIAL SURVEY FOR TEENAGERS

10. What is a Family Planning Clinic? (Tick the <u>one</u> which <u>best</u> describes what it does)
☐1 Somewhere anyone can go for contraception and sexual health services
☐2 Somewhere young families can go for advice
☐3 Somewhere to get milk tokens and other benefits for babies
☐4 Somewhere married people can go for contraception and sexual health services

A "sexual health matter" means anything to do with sex– advice, pregnancy tests, emergency contraception, condoms, pregnancy, sexually transmitted infections etc. 43

11a. Have you ever been to your doctor for contraception or another sexual health matter?

☐1 Yes → **What did you go for most recently?** _____
☐2 No

44-46

11b. Have you ever seen a nurse here for contraception or another sexual health matter?

☐1 Yes → **What did you go for most recently?** _____
☐2 No

12. Have you ever been to a Family Planning Clinic for contraception or another sexual health matter?

☐1 Yes → **Which clinic did you go to most recently?** _____
☐2 No **What did you go for?** _____

13. Have you ever been to the Teenage Advice Clinic here at the surgery for contraception or another sexual health matter?

☐1 Yes → **What did you go for most recently?** _____
☐2 No

14. Have you ever been to a school /college nurse for contraception or another sexual health matter?

56-57

☐1 Yes → **What did you go for most recently?** _____
☐2 No

60

<u>Section Three: About the GP Surgery</u> - This GP surgery aims to be confidential. This means that what you say will not be told to anyone else.

15a. Do you believe that your consultations with the doctor and your records are held in complete confidence?

☐1 Yes ☐2 No → **Why not?** _____

15b. Do you think a Family Planning Clinic would be:
☐1 Less confidential ☐2 As confidential ☐3 More confidential 64

15c. Do you think a Teenage Advice Clinic would be:
☐1 Less confidential ☐2 As confidential ☐3 More confidential

16. How easy would it be for you to get here if you wanted to go to the doctors on your own?

17. Give a score for each of the following, by circling one of the numbers. 5 is the most positive, 1 is the most negative and 3 is neutral:

a. THE RECEPTION STAFF HERE ARE:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unwelcoming	1	2	3	4	5	Welcoming
Unfriendly	1	2	3	4	5	Friendly
Dis-respectful	1	2	3	4	5	Respectful
Unhelpful	1	2	3	4	5	Helpful

Please say why you feel this way or add any other comments about the reception staff:

b. THE DOCTOR I USUALLY SEE IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unwelcoming	1	2	3	4	5	Welcoming
Unfriendly	1	2	3	4	5	Friendly
Dis-respectful	1	2	3	4	5	Respectful
Unhelpful	1	2	3	4	5	Helpful
Rushed	1	2	3	4	5	Takes time to talk to me

Please say why you feel this way or add any other comments about the doctor:

c. THE INFORMATION GIVEN BY THE DOCTOR IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unhelpful	1	2	3	4	5	Helpful
Difficult to Understand	1	2	3	4	5	Easy to Understand

Please say why you feel this way or add any other comments:

_____

_____

d. THE NURSE I USUALLY SEE IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unwelcoming	1	2	3	4	5	Welcoming
Unfriendly	1	2	3	4	5	Friendly
Dis-respectful	1	2	3	4	5	Respectful
Unhelpful	1	2	3	4	5	Helpful
Rushed	1	2	3	4	5	Takes time to talk to me

Please say why you feel this way or add any other comments about the doctor:

_____

_____

e. THE INFORMATION GIVEN BY THE NURSE IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unhelpful	1	2	3	4	5	Helpful
Difficult to Understand	1	2	3	4	5	Easy to Understand

Please say why you feel this way or add any other comments:

_____

_____

f. THE WAITING AREA IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Unpleasant	1	2	3	4	5	Pleasant
Too public	1	2	3	4	5	Private
No useful leaflets	1	2	3	4	5	Useful Leaflets
Nothing for teenagers to read	1	2	3	4	5	Lots for teenagers to read

Please say why you feel this way or add any other comments:

_____

_____

g. THE LOCATION IS:

☹	Very	Fairly	Neither	Fairly	Very	☺
Difficult for most people to get to	1	2	3	4	5	Easy for most people to get
Difficult for me to get to	1	2	3	4	5	Easy for me to get to

Please say why it is easy/difficult to get to or add any other comments:

_____

_____

h. THE OPENING TIMES ARE:

☹	Very	Fairly	Neither	Fairly	Very	☺
Inconvenient	1	2	3	4	5	Convenient
Infrequent	1	2	3	4	5	Frequent

Please say why the opening times are good or bad or add any other comments:

_____

_____

i. OVERALL, how well do you think the doctor's surgery suits you and your needs?

☹	Very	Fairly	Neither	Fairly	Very	☺
Badly	1	2	3	4	5	Well

18. If you could change some things about this doctors' surgery to make it better for young people, what would you change? (please write your answer below)

19. Would you be comfortable coming to the doctors' surgery for contraception or another sexual health matter?

☐₁ Yes – I have already been ☐₂ Yes – I think I would come in the future ☐₂ No

Comments? Think about staff, confidentiality, information, location, appointments etc.

Why Not?

Where would you prefer to go?

Why?

20. Where do you think teenagers would prefer to get the following services from?
In the table below, please put **one tick (✓) on each line** to show where you think teenagers would prefer to go to get free condoms, Emergency Contraception, the contraceptive pill, a pregnancy test or a test for a sexually transmitted disease. If you think teenagers would rather go somewhere not listed, please write this in the last column.

	Hospital	School Nurse	GP / Doctor	Family Planning Clinic	Special Teenage Clinic	Youth Club	Other (Say where)
Free condoms							
Emergency Contraception / morning after pill							
The pill							
Pregnancy test							
Test for a sexual transmitted infection							

21. We know that teenage boys do not often see their doctor for issues about sex, contraception or sexually transmitted infections.
Why do you think this is?

22. Please use the space below to make any other comments you may have about how health services for teenagers could be improved, especially for their sexual health needs:

CONFIDENTIAL SURVEY FOR TEENAGERS

23. Do you think that there are enough local services that teenagers can use if they want advice about sex or contraception?

24. Before you came to the doctors today, did you know that there was a Teenage Advice Clinic here which provides sexual health information and services?

☐1 No
☐2 Yes → **Did you know when it is open?** ☐1 No ☐2 Yes

SAY IF YOU AGREE, DISAGREE OR ARE NEUTRAL (DON'T AGREE OR DISAGREE):

25. My doctor is someone I could talk to if I was worried about anything
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

26. I would trust my doctor to keep anything that I say confidential
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

27. I think my doctor would treat me with respect, whatever I came in for
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

28. Getting a quick appointment at the doctors is difficult
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

29. I would feel embarrassed talking to a doctor about sex or contraception
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

30. If possible, I would prefer to see a doctor/GP who is the same sex as me
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

31. I would be concerned about people seeing me if I went to the doctors about something to do with sex
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

32. I would feel more comfortable talking to a doctor about sex if I could bring a friend
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

33. I would be worried about my parents finding out if I went to the doctors about something to do with sex
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

34. I would be concerned about people seeing me if I went to a Family Planning Clinic about something to do with sex
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

35. I would be worried about my parents finding out if I went to a Family Planning Clinic about something to do with sex
☐1 Agree ☐2 Neutral ☐3 Disagree ☐4 Don't Know

36. I would prefer to have a teenage sexual health clinic based: (Tick one only)

- ☐1 At the doctors
- ☐2 At a Family Planning Clinic
- ☐3 At school
- ☐4 At a youth Club
- ☐5 Somewhere else: **Where?** _____

Section four: More about you

This section asks some more personal questions about you. You do not have to answer them if you don't want to, but it would be helpful for us to know the answers so that we can better understand your health service needs.

37. Have you had sex yet?

- ☐1 No
- ☐2 Yes
- ☐3 I'd rather not say

If you have not had sex yet you do not need to answer any more questions.

Seal this questionnaire in the envelope and EITHER put it in the box at the reception desk OR post it back to us in the FREEPOST envelope provided.

It will not be seen by anyone in the surgery and all your answers will be treated confidentially.

Thank you for your help.

If you have had sex, please answer the remaining questions - all the information you give is anonymous and confidential

38. How old were you the first time you had sex?:

☐1 I'd rather not say ☐2 less than 13 ☐3 13 ☐4 14 ☐5 15 ☐6 16 ☐7 17 ☐8 18 ☐9 19+

39. Did you and your partner use any contraception the first time you had sex?

☐1 No ☐2 Yes → **What?** _____

Where did you get this? _____

CONFIDENTIAL SURVEY FOR TEENAGERS

40. Did you and your partner use any contraception the last time you had sex?

☐₁ No ☐₂ Yes → **What?** _____

Where did you get this? _____

41. How often have you had sex without using any contraception?

☐₁ Never *Go to question 42*
☐₂ Rarely
☐₃ Sometimes
☐₄ Often

41a. Why do you sometimes have sex without contraception?

_____

_____

42. How many people have you had sex with, in total?

☐₁ 1 ☐₂ 2 ☐₃ 3 ☐₄ 4 or more

43. Have all your sexual partners been of the opposite sex? ☐₁ Yes ☐₂ No

44. Have you (or a partner) ever used Emergency Contraception (Morning after pill)?

☐₁ Yes → **How many times?** _____
☐₂ No
☐₃ Don't know

45. Have you (or a partner) ever been pregnant?

☐₁ No
☐₂ Yes → **What happened?** (tick all appropriate)

☐ I'm / she is pregnant now
☐ I / she had the baby **How many?**
☐ I / she had an abortion **How many?**
☐ I / she had a miscarriage **How many?**
☐ Other - state below:

_____

Thank you very much for your help.
Seal this questionnaire in the envelope and EITHER put it in the box at the reception desk OR post it back to us in the FREEPOST envelope provided.
Remember, it will not be seen by anyone here at the doctor's surgery.

Appendix 6
Problems with Contraceptive claim forms (FP1001)

General Practices can claim payment for contraceptive advice given to any women in their practice by making an annual contraceptive claim (CC). This is claimed through a central office at N&E Devon Health Authority. There used to be greater difficulties in claiming this payment, as a signature was required from each woman to say that she had received such advice. With current computer systems, most practices claim directly on computer using the GP link system. Claims are recorded each quarter and payments made relating to the financial year.

In practice, some claims may not be made due to administrative error or lack of time -especially in emergency appointments (such as for EC). In addition, individual practices may have different policies for claiming - the payment is made for advice, but how this is interpreted may differ form doctor to doctor, practice to practice and within the HA. One N. Devon GP has recently had her claims questioned. This GP offers a special service to teenagers who are invited to the practice for an advice consultation. The consultation covers teenage issues including spots, periods, smoking, drinking and sexual health. The GP claims CC for all the girls she sees, whether or not contraception is needed or supplied, because she has given advice. This is in the spirit of the current allowance but has in fact been queried by the payments office because contraception is not supplied. Other practices may also have similar differences in claiming for different types of consultation relating to contraception.

The main measurement in the research proposal to measure the success of the project was a 10% increase in the number of contraceptive claim (CC) forms issued by the TAC practices. In order to calculate this, it is necessary to establish not just the numbers but the proportions of teenager in each practice for whom CC forms exist. However, the CC claims forms do not appear to be a reliable indicator of activity within practices and data differs in all cases from that collected for the project. This is likely to be a more comprehensive indication of practice activity as it includes consultations made for advice, as well as for sexual health consultations other than contraception such as STIs and referrals.

Details of the numbers of Contraceptive claims made were given in different forms for 1997 and 1999. 1997 CC details were available by individual age 13-19 but for 1999 were only available for under 15s, age 15 and 16-19. In addition, the 1997 figures were provided for that calendar year. The 1999 figures actually cover the financial year, April 1999-March 2000. TAC clinics were running for most of this period. The figures for CC forms are given overleaf.

In 1997, all the case practices together had CC forms for 467 teenage girls, 24.2% of their female teenage practice population of 1932. Control practice had CC forms for 493 teenage girls, 25.1% of their female teenage population of 1967. This suggests that the case and control practices are seeing similar numbers of teenager for contraception, and making claims in a similar way.

In 1999, all the case practices together had contraceptive claim forms for a total of 22.6% of their teenage girls and control practices for 21.7%. Again, similar proportions of teenagers were being seen by cases and controls. There has been an overall decrease in the proportion of teenage girls seen for contraception although the difference is small

Contraceptive claims by age in each participating practice for 1/1/97 - 31/12/97 & 1.4.99 - 31/3/00

	1997				1999				
	13-15 CC form	16-19 CC form	All age 13-19	% with CC form	13-15 CC form	16-19 CC form	All age 13-19	% with CC form	Change
Case 1	8	118	126	26.1	7	105	112	22.9	-4.1
Control 1	16	152	168	27.0	10	142	152	23.1	-3.9
Case 2	8	109	117	21.6	9	132	141	23.9	+2.3
Control 2	19	105	124	24.3	13	112	125	21.6	-2.7
Case 3	2	38	40	17.4	4	39	43	17.1	-0.3
Control 3	3	48	51	25.8	7	64	71	34.8	+9.0
Case 4	4	72	76	22.6	3	76	79	18.3	-4.3
Control 4	3	36	39	12.4	7	38	45	13.6	+1.2
Case 5	12	96	108	31.4	8	97	105	29.2	-1.1
Control 5	9	102	111	34.7	8	53	61	18.8	-15.9
All cases	34	433	467	24.2	31	449	480	22.6	-1.6
All controls	50	443	493	25.1	45	409	454	21.7	-3.4

Appendix 7

RECORDS OF SEXUAL HEALTH CONSULTATIONS FOR TEENAGERS 1997 ***CONFIDENTIAL***

SURGERY CODE:_____

1. Patient Initials ☐☐ *1-2* **2. Patient D.O.B.** ☐☐/☐☐/☐☐ *3-8*

3. Registered at this Practice ☐1 Yes ☐2 No *9*

4. Total Number Visits ☐ *10*

5. Seen by nurse ☐ **times** *11*

6. Seen by doctor ☐ **times** *12*

7. Seen for the first time ever for sexual health advice this year? Yes☐1 No ☐2 Don't Know ☐3 *13*

8. Which contraceptives were prescribed by your surgery in 1997? *14-22*

Yes ☐1 No ☐2 Combined OC *14* → COC brand changed this year? → ☐1 No
Yes ☐1 No ☐2 Progesterone only pill *15* → POP brand changed this year? → ☐2 Yes once
Yes ☐1 No ☐2 Condoms - supplementary *16* ☐3 Yes more than once
Yes ☐1 No ☐2 Condoms - main method *17* ☐4 Not applicable *22*
Yes ☐1 No ☐2 Depo-Provera *18*
Yes ☐1 No ☐2 Norplant *19*
Yes ☐1 No ☐2 Cap/Diaphragm *20*
Yes ☐1 No ☐2 IUD/IUS *21*

9. Cervical smear performed?

☐1 Yes → **Result** ☐1 Normal
☐2 No *23* ☐2 Inadequate → **Repeat smear?** No ☐1
☐3 Borderline/mild → Yes ☐2 *25* → ☐1 Normal *26*
☐4 Moderate/severe *24* ☐2 Inadequate
☐3 Borderline/mild
☐4 Moderate/severe

10. How many times prescribed hormonal Emergency Contraception (PC4)? ☐ *27*

11. How many times fitted with IUD as Emergency Contraception? ☐ *28*

PLEASE TURN OVER

RECORDS OF SEXUAL HEALTH CONSULTATIONS FOR TEENAGERS 1997 ***CONFIDENTIAL***

SURGERY CODE:_____

12. Number of times seen for sexual health/contraceptive advice only: ☐ 29

13. Number of times seen to start a new or different contraceptive method: ☐ 30

14. Number of times seen for check of or repeat contraceptive provision: ☐ 31

15. Number of pregnancy tests: **Performed on the spot:** ☐ 32 **Sent away** ☐ 33

16. Number of negative results ☐ 34 **Number of positive results** ☐ 35

Outcome:
☐1 Miscarriage
☐2 Birth
☐3 TOP
☐4 In 1998
☐5 Unknown 36

Conceived 1996? Yes ☐1 No ☐2 37

17. Number of Vaginal Swabs taken: ☐ 38 **Positive for:**
☐1 Chlamydia
☐2 Viral infection
☐3 Bacterial Infection
☐4 PID
☐5 Other (state) _____
☐6 None 39-44

18. Referrals to other agencies this year:

Counsellor 45 Yes ☐1 No ☐2 GUM 46 Yes ☐1 No ☐2

FPC 47 Yes ☐1 No ☐2 Gynaecologist 48 Yes ☐1 No ☐2

Other (state)_____ 49

19. Comments: ***use this space to clarify any unclear answers, or to add additional information about this patient in 1997***

Appendix 8

SURGERY CODE:_____ 1-2 DATE OF VISIT ☐☐/☐☐/☐☐ 3-8

1. Patient Initials: ☐☐ 9-10 2. Patient D.O.B. ☐☐/☐☐/☐☐ 11-16

3. Registered at this Practice: ☐1 Yes ☐2 No 17

4. Contraceptive Claim form: ☐1 Existing ☐2 Completed today 18

5. First ever sexual health consultation today? 19 ☐1 Yes ☐2 No ☐3 Don't Know

6. Seen by: ☐1 Doctor ☐2 Nurse 20

7. Contraceptives prescribed: 21

☐1 Combined OC → ☐1 Tick if pill brand changed 22
☐2 Progesterone only pill →
☐3 Condoms
☐4 Depo-Provera
☐5 IUD
☐6 Cap/Diaphragm
☐7 Other (Please state) _____

8. Emergency Contraception supplied:

☐1 PC4
☐2 IUD
23

9. ☐1 Given contraceptive advice/ information ONLY 24

10. Pregnancy test: 25 ☐1 Performed on the spot ☐2 Sent away ☐3 Done at home

Result: ☐1 Positive ☐2 Negative 26

Outcome: ☐1 Miscarriage ☐2 Birth ☐3 TOP ☐4 Unknown 27

11. Cervical smear performed? ☐1 Yes, initial ☐2 Yes, repeat 28 → Result: ☐1 Normal ☐2 Inadequate ☐3 Borderline/mild ☐4 Moderate/severe 29

12. ☐1 Tick if vaginal swab taken 30

Positive for: ☐1 Chlamydia ☐2 Viral infection ☐3 Bacterial Infection ☐4 Candida ☐5 Other (state) _____ 31

13. Referred to another agency: ☐1 Counsellor ☐2 GUM ☐3 FPC ☐4 Gynaecologist ☐5 Other (state) _____ 32

14. Additional information:

Appendix 9

CLINIC ID [ ] *1-2* **FILL OUT THIS PAGE AT FIRST VISIT ONLY** **PATIENT ID** [ ] *3-4*

1. Surname: _____ **First Name:** _____

2. Date of Birth: [ ][ ]/[ ][ ]/[ ][ ] *5-10* **3. Marital Status:** [ ]$_1$ Single [ ]$_2$ Married *11*

4. Date of first visit: [ ][ ]/[ ][ ]/[ ][ ] *12-17* **5. Sex** [ ]$_1$ Male [ ]$_2$ Female *18*

6. Current residence: [ ]$_1$ With 1 Parent [ ]$_2$ With both parents [ ]$_3$ With parent and step-parent
[ ]$_4$ Alone [ ]$_5$ With Partner [ ]$_6$ With Friend(s)
[ ]$_7$ Other (state) _____ *19*

7. Occupation: [ ]$_1$ At school - state year _____ [ ]$_2$ VIth Form College [ ]$_3$ University Student
[ ]$_4$ Employed [ ]$_5$ Unemployed [ ]$_6$ Training
[ ]$_7$ Other (state) _____ *20*

8. Existing Drug Treatments: [ ]$_{01}$ None or State: _____ *21-22*

9. Allergies: [ ]$_{01}$ None or State: _____ *23-24*

10. Blood Pressure: [ ]$_1$ Not Taken or State$_2$: _____/_____ *25*

History of:
11. Migraine [ ]$_1$Yes [ ]$_2$ No **14. Thrombosis** [ ]$_1$Yes [ ]$_2$ No
12. Jaundice [ ]$_1$Yes [ ]$_2$ No **15. Epilepsy** [ ]$_1$Yes [ ]$_2$ No
13. Smoking [ ]$_1$Yes [ ]$_2$No **16. Vaginal Discharge** [ ]$_1$Yes [ ]$_2$ No *26-31*

17. Family History of: **Diabetes** [ ] Mother [ ] Father *32-33*
Heart disease [ ] Mother [ ] Father *34-35*
Other _____ *36-37*

18. Last Menstrual Period: Date _____ *38-43* **19. Period was:** [ ]$_1$ Normal [ ]$_2$ Abnormal *44*

20. Cycle: [ ]$_1$ Regular → Length _____ days *46-47*
[ ]$_2$ Irregular *45* or [ ]$_{01}$ Unsure

21. Menstrual Problems? [ ]$_1$ No
[ ]$_2$ Yes - State: _____ *48*

22. Current contraceptive method: [ ]$_1$ None [ ]$_2$ Condom [ ]$_3$ COC [ ]$_4$ Other (state) _____ *49*

23. Obtained from: [ ]$_1$ Own GP [ ]$_2$ Other GP [ ]$_5$ Other (state) _____ *50*
[ ]$_3$ FPC [ ]$_4$ Retail outlet

24. Recent unprotected sex? [ ]$_1$ Yes → **Date:** _____ *52-55* **Time:** _____ *56-59*
[ ]$_2$ No *51*

25. Previous pregnancies:
Births Number _____ Date(s) _____ *60-66*
Terminations Number _____ Date(s) _____ *67-73*
Miscarriages Number _____ Date(s) _____ *74-80*

26. Ever consulted for sexual health matters before? [ ]$_1$ No *81*
[ ]$_2$ Yes → (tick all) [ ]$_1$ GP [ ]$_2$ FPC [ ]$_3$ A&E [ ]$_4$ Other *82-85*

27. Happy for GP to be informed? [ ]$_1$ Yes **Dr name & address:** _____
[ ]$_2$ No _____ *86*

28. Other comments:

CLINIC ID [ ] *1-2* DATE: [ ][ ]/[ ][ ]/[ ][ ] *3-8* PATIENT ID *9-10* [ ]

1. Patient seen:
[ ]$_1$ Alone
[ ]$_2$ With partner
[ ]$_3$ With parent
[ ]$_4$ With friend(s) *11*

2. Consulted for sexual health since last visit?
[ ]$_1$ N/A
[ ]$_2$ Yes → Tick all that apply:
[ ]$_3$ No *12*
[ ] GUM [ ] FPC
[ ] GP [ ] A&E
[ ] Other(state) _____ *13-17*

3. What did the patient say s/he wanted? (Tick all that apply)

[ ] General contraceptive discussion	*18*
[ ] Specific contraception requested	*19*
[ ] Pregnancy test	*20*
[ ] Emergency Contraception	*21*
[ ] Advice about a pregnancy	*22*
[ ] Advice about relationships	*23*
[ ] Advice about STI/HIV	*24*
[ ] Information about diet/weight	*25*
[ ] Smoking advice	*26*
[ ] Skin problems	*27*
[ ] Other (state) _____	*28-29*

4. Areas discussed (tick all that apply):

[ ] Relationships	*30*
[ ] Range of contraception available	*31*
[ ] Specific method	*32*
[ ] Possible problems/side effects	*33*
[ ] Factors associated with method failure	*34*
[ ] EC availability	*35*
[ ] STI/HIV protection	*36*
[ ] Pregnancy choices	*37*
[ ] Diet/weight	*38*
[ ] Smoking	*39*
[ ] Skin problems	*40*
[ ] Other (state) _____	*41-42*

5. Contraception given?
[ ]$_1$ Yes (state what) → [ ]$_1$ Condom
[ ]$_2$ No *43* [ ]$_2$ COC
[ ]$_3$ Other: (state) _____ *44*

6. Referral made? [ ]$_1$ No
[ ]$_2$ Yes → [ ]$_1$ GP
45 [ ]$_2$ GUM
[ ]$_3$ FPC
[ ]$_4$ Gynae
46 [ ]$_5$ Counsellor

7. EC provided? [ ]$_1$ Yes
[ ]$_2$ No
47

8. Pregnancy test done? [ ]$_1$ No *48*
[ ]$_2$ Yes → [ ]$_1$ Negative
[ ]$_2$ Positive
OR (results in _____ days)$_3$ *49*

10 Swab taken? [ ]$_1$ Yes
[ ]$_2$ No *50*

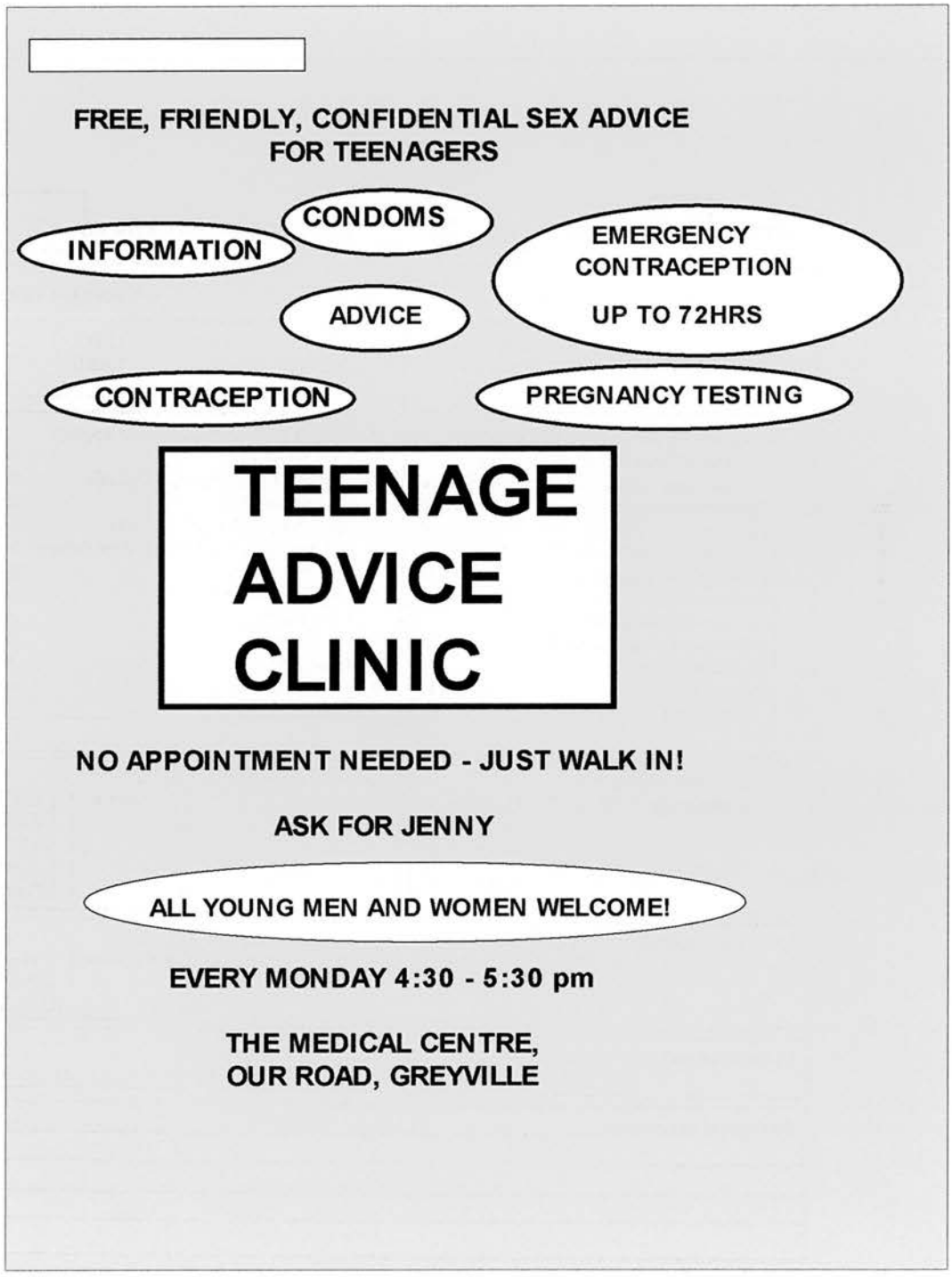
11. Smear taken? [ ]$_1$ Yes
[ ]$_2$ No *51*

Additional comments:

ENSURE PROTOCOLS FOLLOWED ARE RECORDED FOR EVERY CONSULTATION

PROTOCOLS FOLLOWED:	Date	Signature
COC		
POP		
Depo Provera		
EC		
Under 16s		

Appendix 10


FREE, FRIENDLY, CONFIDENTIAL SEX ADVICE
FOR TEENAGERS
INFORMATION
CONDOMS
ADVICE
EMERGENCY
CONTRACEPTION
UP TO 72HRS
CONTRACEPTION
PREGNANCY TESTING
TEENAGE
ADVICE
CLINIC
NO APPOINTMENT NEEDED - JUST WALK IN!
ASK FOR JENNY
ALL YOUNG MEN AND WOMEN WELCOME!
EVERY MONDAY 4:30 - 5:30 pm
THE MEDICAL CENTRE,
OUR ROAD, GREYVILLE

Appendix 11

DROP-IN CLINIC PROTOCOLS Under 16s

Some under 16s are sexually active and this group is often particularly vulnerable because they are less likely to use contraception, more likely to be concerned about confidentiality when going to a health professional for advice or supplies and more likely to have multiple partners. Reaching sexually active under 16s is an aim of the drop-in project.
The 1985 House of Lord's ruling on the Gillick case established the current legal framework for England and Wales which states that people under 16 who are fully able to understand what treatment is proposed and its implication are competent to consent to such treatment. When seeing under 16s for contraceptive advice the following points must be boume in mind:

1) Whether the client understands the potential risks and benefits of the treatment and advice given.
2) The value of parental support should be discussed and under 16s should be encouraged to inform their parents that they have sought contraception. It is important that the young person is made aware that there is a legal obligation on the part of the health professional to discuss the value of parental support, but that confidentiality will still be respected.
3) The health professional should take into account whether the client is already having sexual intercourse or is likely to do so without contraception.
4) Whether the clients mental or physical health is likely to suffer if the client does not receive contraceptive advice or treatment.
5) Whether the young person's best interests would require the provision of contraceptive advice or supplies or both without parental consent.
These points must be satisfied before treatment is undertaken. The House of Lords further ruled, following the Gillick case that:

> 'A girl under 16 of sufficient understanding and intelligence may have the legal capacity to give valid consent to contraceptive advice and treatment including necessary medical examinations
> Giving such advice and treatment to a girl under 16 without parental consent does not necessarily infringe parental rights
> Health professionals giving such advice in good faith are not committing a criminal offence of aiding and abetting unlawful intercourse with girls under 16.'

Confidentiality Within The Drop-In Clinics
The clinics aim to run a confidential service and this should be respected at all times.
Confidentiality is major issue for teenagers attending services for information about sex and contraception. It is important that those attending also realise that they have a duty of confidentiality to others they see attending the clinic.
Although there is no statutory right of confidentiality, all those in the NHS are under a legal duty to safeguard confidentiality, health professionals also have an ethical obligation to do so.
Confidentiality may only be breached where the disclosure is justified in the public interest, or authorised by the individual, law or Court Order.
Accountability for confidentiality rests with the individual health care practitioner. Any details shared with the research team will be treated with the utmost confidence - any reporting of the individuals will be anonymised.

Confidentiality Criteria

1) All information gained concerning the young person, members of staff and the work organisation obtained through the course of professional practice will be treated as confidential and used only for the purposes for which it was given.

2) All health care professionals must ensure that they do not become channels through which confidential information is released - this means that care should be taken to avoid discussions of the clinic business in a public place or health care environment which is not private.

3) All client records and other confidential information must be stored in a private and secure place both within the clinic and any records held for research purposes at the University of Exeter.

4) All health care practitioners should ensure that those using the drop-in are aware of the principles of confidentiality INCLUDING the need, where necessary, to share confidential information with other health care staff if required in order to provide good care, and that this information remains in the strictest confidence.

5) Client consent should be sought before sharing information with other health or social service professionals.

6) Clients should not be acknowledged outside the clinic setting unless the health care worker is approached first

In the event that a parent wishes to be informed about the services being provided to their child, or requests access to their records the following sequence will be followed.

Record Keeping The Data Protection Act (1984) - in Brief!

1) Personal data is held for one or more lawful purpose.

2) Personal data is not disclosed or used for any other purposes(s) than those identified.

3) Personal data is adequate, relevant and not excessive in relation to the intended purposes.

4) Personal data is accurate and kept up to date.

5) Personal data is not kept for longer than is necessary.

6) Appropriate security measures are taken against unauthorised access to alteration, disclosure, destruction and loss.

7) Individuals have the right to access personal data at reasonable intervals and without undue delay and to have the information rectified if it is inaccurate and the right to seek compensation for damage and distress caused by loss, unauthorised destruction or unauthorised disclosure of personal data.

Record Keeping and Protocols

Records should show that relevant protocols about contraceptive issuing and the treatment of under 16s have been followed where appropriate.

Parental Access to Young People's Health Records

If a parent requests access to a young person's records, the following, written in line with the Access to Health Records Act (1990) should be followed:

1) A parent contacting the clinic wishing to see the records of their child should be given the opportunity to discuss any anxieties they may have without divulging whether their child is attending and if such records exist.

2) If the parent continues to ask to see the records of their child, they should be informed that under the Access to Health Records Act (1990), such requests need to be seen in writing.

3) On receipt of a letter from a parent requesting access to their child's records, it should be established whether or not this person is a client, and their age.

4) For clients under the age of 16 Letter 1 is sent to the young person and letter 2 to the parent (see below) For clients over 16, letter 3 is sent to the parent.

5) When a reply is received from an under 16, send letter 3 if consent is refused. If consent is give by the client the notes should be reviewed to establish whether the information provided by the client and recorded in their notes was given in the expectation that it would not be disclosed to the parent. If so. Letter 4 should be sent to the parent.

Letter 1 Dear

Access to Health Records

Your parents/mother/father/guardians have/has written to the drop-in clinic inquiring as to whether you are a client and requesting access to any medical records of yours that we have.

Under the Access to Health records Act (1990) any young person under the age of 16 has the right to decide whether or not their parents can see their medical records. For young people over 16 years, only the young person has a right of access.

Please complete the return slip at the bottom of this letter marking to show if you are happy for your parent(s) to see all or part of your health records that we may have or not. Return the slip in the stamped addressed envelope provided.

If you are puzzled by this letter, you may wish to discuss your parents request with us in confidence. Please call into the drop-in if you wish to do so.

Remember, the drop-in will always respect the decision that any young person makes regarding their health records. We have not and will not tell your parents whether or not we have any health records of yours unless you give your written permission.

Yours sincerely,

Please complete and return this section in the SAE provided
Date: _____ Print name: _____

I do / do not want my parent(s) to see any health records of mine you may have at the clinic.

Signed _____

Letter 2 Dear

Access to Health Records

In response to your written request for access to the health records of your son/daughter, _____, I must inform you that the Access to Health records Act (1990) requires that a young
person under the age of 16 consent to the making of this application.

If your son/daughter has been to the drop-in clinic we must first receive their written permission to give you access to their health records.
Once this has been received I will consult with the appropriate health professionals before writing

to you again. Yours sincerely,

Letter 3 Dear

Access to Health Records

In response to your written request for access to the health records of your son/daughter, _____, I must inform you that it is the drop-in clinic's policy only to provide this information
directly to the client as set out in the conditions of the Access to Health records Act (1990).
If, however, you would like further information on the services we provide to all young people at the drop-in clinic we would be happy to provide this. Please telephone and ask for _____ as I am happy to
discuss this with you at any mutually convenient time.

Yours sincerely,

Letter 4 Dear

Access to Health Records

In response to your written request for access to the health records of your son/daughter, _____, I must inform you that I have consulted with the appropriate health professional and
have decided to refuse your application in line with the condition set out in the Access to Health records Act (1990). The reason for the refusal is that in our opinion, your son/daughter provided the information contained within the health records in the expectation that it would not be disclosed to you or any other third party.
If, however, you would like further information on the services we provide to all young people at the drop-in clinic we would be happy to provide this. Please telephone and ask for _____ as I am happy to
discuss this with you at any mutually convenient time.

Yours sincerely,

Child Protection

Drop-in clinic staff should be familiar with procedures for young people and child protection outlined in the Devon Multi Disciplinary Child Protection Handbook.
Nurses are personally accountable for their own individual actions under the UKCC Code of Professional Conduct, nurses must:

> "protect all confidential information concerning patients and clients obtained in the course of professional practice and make disclosures only with consent, where required 'by the order of the court or where you can justify disclosures in the wider public interest"
>
> UKCC Advisory Paper

Following any disclosure of abuse, all observations and actions should be put in writing as soon as possible and clearly signed and dated. If a person discloses sexual abuse or is thought to be at risk of sexual abuse, note the information but do not question further or cross-examine. If there are suspicions or concerns that a young person *may* be in need of protection from abuse, the case may be discussed with the Social Services Department or with die senior Nurse Child Protection.

DROP-IN CLINIC NURSE - JOB DESCRIPTION

The nurse staffing the drop-in clinic will provide contraceptive advice and supplies to under 20s on a non appointment basis for a hour a week. This will include:

Record keeping for both the clinic and associated research
Emergency Contraception provision and follow-up
Condom provision and instruction
OC provision
Pill checks
Pregnancy tests
Advice about TOP and referrals
Taking swabs where necessary and referral to GUM as necessary
Offering practice appointments and follow up
Information and education on chosen methods of contraception and on sexual health and other health issues as appropriate.

The nurse should liase with the research team about the clinic running and its ability to meet client needs.
The nurse should be responsible for setting up the clinic and dismantling any aspects required for its weekly running,

The nurse should liase with GPs and other practice staff for advice and for client referrals as necessary.

Appendix 12

The questions below will help us to match General Practice characteristics before allocating them to control, or drop-in groups for this project

1. Would you describe your practice as [ ] Rural [ ] Suburb
[ ] Town [ ] City-centre

2. How many full-time equivalent principals are there in the practice? [ ]

3. How many of these are female? [ ]

4. How many of these have the Family Planning Certificate? [ ]

5. Does the Practice Nurse have Family Planning training? [ ] Yes
[ ] No

6. Will you provide contraceptive services and advice to those NOT registered in your practice? [ ] Yes
[ ] No

7. What percentage of your patients attract a deprivation allowance? [ ] %

8. Do posters advertise your Family Planning services? [ ] Yes
[ ] No

9. Are contraceptive leaflets available in the waiting area? [ ] Yes
[ ] No

10. Do you advertise confidentiality for Family Planning Service users? [ ] Yes
[ ] No

11. Which of the follow are currently provided at your practice (Tick all you provide)

[ ] Oral contraception
[ ] Injectables
[ ] Implants (insertion and removal)
[ ] IUD fitting
[ ] Diaphragm/cap fitting
[ ] Condoms
[ ] Spermicides
[ ] Vasectomy advice/referral
[ ] Vasectomies performed in the practice
[ ] Female sterilization advice/referral
[ ] Urgent access to Emergency Contraception
[ ] Advice on natural family planning methods
[ ] Counselling for unplanned pregnancy
[ ] Referral for termination of pregnancy
[ ] Free pregnancy testing on the spot
[ ] Counselling around HIV/AIDS issues
[ ] Referrals for Sexually Transmitted Infections

→
PLEASE TURN OVER

12. Are you on the computerised GP Link? [ ] Yes
[ ] No

13. Do you currently run any special sexual health sessions? [ ] No
[ ] Yes
(describe below)

_____

_____

14. Do you currently run any special services for teenagers? [ ] No
[ ] Yes
(describe below)

_____

_____

15. How would you describe public transport access to your clinic: [ ] Good
[ ] OK
[ ] Poor

16. How close is your practice to local secondary schools? [ ] miles (approx.)

It would be helpful if you could supply the following information, if this is not readily available we can obtain it from the community trust:

How many patients are registered in your practice? [ ]

How many are women 13 - 45? [ ]

How many are teenage girls 13-19? [ ]

How many are teenage boys 13 -19 ? [ ]

Thank you for your help - please use the space below for any additional information or comments you may have.

_____

_____

_____

_____

_____

_____

_____

Please return this completed form to IPS in the envelope provided.